

The Diocese of Bridgeport Claim Form for the 2011 Plan Year

Medical Claim
 Dependent Care Claim

Employee Information:

Employee Name: _____ Social Security Number: _____ - _____ - _____
 Address: _____ State: _____ Zip: _____ Changed?
 Phone: (_____) _____ - _____ E-mail: _____

Place of Work: _____

Claim Information:

Name of Member	Date(s) of Service (Ex: Exam, Copay, Coinsurance, Daycare)	Description of Service (Doctor, Hospital or Day Care Provider)	Name of Provider	Claim Amount
1 _____ Relationship: _____	____/____/____ to ____/____/____			\$ _____
2 _____ Relationship: _____	____/____/____ to ____/____/____			\$ _____
3 _____ Relationship: _____	____/____/____ to ____/____/____			\$ _____
4 _____ Relationship: _____	____/____/____ to ____/____/____			\$ _____
5 _____ Relationship: _____	____/____/____ to ____/____/____			\$ _____

TOTAL: \$ _____

Instructions

- Incomplete forms will be returned for further information;
- If this is a Dependent Care Receipt, you must enter both the start and completion date. In addition, the receipt must have the Provider's Federal Tax ID or Social Security Number;
- Dates of Service must be within the 2011 Plan Year (or extension if offered);
- Photocopies of your receipt (proving payment) must be attached or faxed with claim form. Copies of credit card receipts or personal checks are not acceptable documentation; and
- Claim Form must be signed and dated (below).

Mail, Fax or E-Mail Claim Form with corresponding receipts to: Benefit Planning Services, LLC, PO Box 551, Norwalk, CT 06852. Fax: 203-840-8880 e-mail: pagano@bpsllc.com
 If you have any questions, please call MaryAnn Pagano at (800) 378-7526.

IMPORTANT: Signature: _____ Date: _____