Manual Claim Form

Send completed form:
Email: Claims@CoeurPlanServices.com
Fax: 210-981-1210
Mail: P.O. Box 592869, San Antonio, Tx 78259

Employer Name _____ **Group #** _____

Policyholder Information

Full Name _____
Last First Middle Initial

Member ID or SS# _____ **Date of Birth** _____ **Gender** ☐ M ☐ F

Address _____
☐ Check for New Address
Street City State Zip

Email Address _____ **Phone Number** _____

Patient Information (Complete only if different than Policyholder Information)

Full Name _____
Last First Middle Initial

Member ID or SS# _____ **Date of Birth** _____ **Gender** ☐ M ☐ F

Address _____
☐ Check for New Address
Street City State Zip

Email Address _____ **Phone Number** _____

Provider Information Attach copies of itemized bills. Complete only if itemized bill is not available.

Provider Name _____

Provider Tax ID # _____ **Phone Number** _____

Address _____
Street City State Zip

Claim Details Medical, Dental & Vision Claim Reimbursements. Complete only if itemized bill is not available.

Date of Service MM/DD/YY	Description of Service	Place of Service	Diagnosis Code	Procedure Code	Charges
				TOTAL AMOUNT REQUESTED $	

Request from provider a detailed Invoice or Superbill to include: Patient Name; Description of Service, Dates of Service; Place of Service; Diagnosis Code; Procedure Code; and Billed amount for each procedure.

Certification of Statement

I certify that all the above statements are correct and that the attached bills represent actual services, dates and fees charges to me or my eligible dependents. Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information, may be guilty of a criminal act punishable under law and may be subject to civil penalties.

Signature: _____ **Date:** _____