Custom Design Benefits

Medical Claim Form

Submit Claims To:
Custom Design Benefits
5589 Cheviot Rd
Cincinnati, OH 45247
Ph: (800) 598-2929
Fax: (513) 389-2998
Claims@CustomDesignBenefits.com

Please attach any applicable receipts *Use one form for each provider.*

Employee Name | Member ID

Address | Phone

City | State | Zip | Email

Patient Name | Patient Birth Date

Relationship to Employee ◯ Self ◯ Spouse ◯ Child

Is Claimant Covered under another Plan? ◯ Yes ◯ No If yes, please attach the primary explanation of benefits.

***NOTE:* This claim cannot be processed without these required fields: Date of Service, CPT/HCPS Code, Diagnosis Code, Charge Amount, Provider Name/NPI and Provider Tax ID Number.**

Date of Service	CPT/HCPCS Code	Diagnosis Code	Charge Amount

Provider Name/NPI | Provider Tax ID Number

Address | Phone

City | State | Zip

Provider Signature | Date

I certify that the information reported above and attached to this claim form is accurate to the best of my knowledge.

Employee Signature | Date