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

Medical Claim Form

******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