Custom Design Benefits

HIP CLAIM FORM

Submit Claims To:
Custom Design Benefits, Inc.
5589 Cheviot Road
Cincinnati, Ohio 45247
Ph: (800) 598-2929
Fax: (513) 598-7795 or 3668
HIP@CustomDesignBenefits.com

Employee Name: _____ Social Security Number: _____

Address: _____ ☐ check if new Date of Birth:_____

City/St/Zip_____ Phone: _____ Email address:_____

WHAT WE NEED. Please provide all documentation requested and review the total expense amounts before submitting the claim. Please include the following with your claim(s):

Medical Claims	▪ Primary Carrier EOB (Explanation of Benefits) ▪ Provider Statement, HCFA or UB92/UB04 Forms. Must show services rendered and dates of service
Pharmacy Claims (Please do not submit claims processed through HealthSmart)	▪ Bag receipt, pharmacy print-out or Primary Carrier EOB showing amount applied to Deductible or Out-of-Pocket. These should show the name of patient, drug name, date of fill, and cost. Cash register receipts and credit card statements do not contain enough info for HIP Claim submissions.

CLAIMS RECEIVED LESS THAN 24 HOURS PRIOR TO SCHEDULED REIMBURSEMENT DATE WILL BE PROCESSED ON THE NEXT SCHEDULED REIMBURSEMENT DATE.

Date(s) Expense Incurred	Name of Service Provider	Expense Description	Claimant Name	Amount
Attach requested documentation and submit with this claim form. Please keep a copy for yourself.			**Total Healthcare Expense:**	**$** $ 0.00

Read Carefully: The undersigned participant in the Plans certifies that all services for which reimbursement or payment is claimed by submission of this form were provided during a period while the undersigned was covered under the Company's Plans with respect to such expenses and that the health expenses have not been reimbursed or are not reimbursable under any other health plan coverage. The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim which is provided by the undersigned, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the Plan, the undersigned may be liable for payment of all related taxes including federal, state, or city income tax on amounts paid from the Plans which relate to such expense.

_____ _____

Employee's Signature Date

Visit www.CustomDesignBenefits.com and login to **HealthVu** to view HIP Claims online along with other info about your HIP Plan.