EME PLAN CLAIM FORM

Frontier Communications

Direct Mail all claims to:
Frontier Communications
Attn: Retiree Medical Department
401 Merritt 7
Norwalk, CT 06851

EMPLOYEE/RETIREE/SURVIVOR PERSONAL INFORMATION (Please print clearly)

Name (Employee, Retiree, or Survivor)

Address_______________________________________

City/State_____________________________________

ZipCode______________________________________

Alpha Prefix/Social Security/ID Number:__________________

PATIENT INFORMATION

Patient's Name: ____

Patient's Social Security: ___ ___ ___- ___ ___ ___ - ___ ___ - ___ ___ ___ ____

Patient's Date of Birth (mm/dd/yy): _______________________________

Relationship of Patient: ( ) Self ( ) Husband ( ) Wife ( )Daughter ( ) Son ( ) Stepdaughter/legal guardian ( ) Stepson/legal guardian

Does patient have Medicare coverage? ( ) No ( ) Yes

Medicare Part A (Hospital) ( ) Medicare Part B (Doctor) ( )

Effective date of Medicare Part A _________ Effective date of Medicare Part B _____________

Reason for Claim:

( ) Prescription Services ( ) Medical Services

Amount of Expenses to be considered: $_____________________________

PROVIDER INFORMATION Name_________________________________

Billing Address :____________________________ Provider Phone Number______________

Provider's Tax ID____________________________

AUTHORIZATION TO RELEASE INFORMATION:

I authorize any insurance company, employer, organization or provider of service to release any information related to this claim to Frontier Communications or its authorized contractor before or after payment.

I have reviewed the accompanying charges and my signature below verifies their accuracy and authorizes payments as indicated:

Signature:____ **Date:**__________________ ( ) Pay Member

Patient's (even if employee) or parent or guardian of minor

FRONTIER COMMUNICATIONS EME PLAN CLAIM FORM FILING INSTRUCTIONS

1. Complete a separate claim form for each patient.
2. Complete the **Personal Information** section. *(Please print clearly)*
3. Complete the **Patient Information** section. *(Please print clearly)*
4. Attach all corresponding bills. All bills must show:
   - Patient name
   - Date of service
   - Copy of the explanation of benefits showing the qualifying Out of Pocket expenses
   - Type of service
   - Procedure code or prescription number and prescription name
   - Amount of charge for services
   - Provider Federal Tax ID number (if available)
   - Provider address

   Keep a copy of all bills for your records.
5. If the patient has Medicare or other group health insurance coverage that is primary (pays first):
   - Submit your claim to the primary coverage first
   - After the primary coverage has processed your claim, complete the EME claim form
   - Attach the explanation of benefits (EOB) from the primary coverage **and** a copy of the original bill to the claim form
   - Submit your claim to Frontier Communications for processing at:

Frontier Communications
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Norwalk, CT 06851

All health claims must be submitted within 12 months of the date of service to be eligible.