

Children's Providers Trust Administrators Claim Form

EMPLOYEE INFORMATION

Employee Name:	_____	SS#:	_____
	First Last		
Employee Address:	_____		
Patient Name:	_____	DOB:	_____
	First Last		
Date(s) of Service:	_____		

Please attach original Explanation of Benefits (EOB) from Blue Shield for this claim. **All EOB's must be submitted no later than June 30th of the following year for consideration of reimbursement.**

Do you have other medical insurance? Yes No

If so, you must also attach the EOB from that insurance for this claim.

Please submit to: **Children's Trust Providers, PO Box 3301, Chico, CA 95927-3301**

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