Health Insurance Assistance Programs Medical Out-of-Pocket Claim Form

Submitter must complete Sections A and B. This claim form AND supporting documentation (Explanation of Benefits and an invoice) must be sent to Pool Administrators, Inc. (PAI). If you have any questions about submitting this form, please contact PAI Customer Service at (877) 495-0990.

Electronically: Payer ID: PAI02
Fax: (860) 560-8225
Email: CDPH_MBM_Fax@pooladmin.com
Mail: PAI-CDPH-01, 628 Hebron Ave., Suite 502, Glastonbury, CT 06033

A. Client Information

First Name:________________________________ Last Name:_____________________________________

Date of Birth:____________________ Client ID number:______________________

Client Mailing Address:____

City:_______________________ State:_________ Zip Code:____________________

Spousal Claim Name:______________________________ Client ID:_______________________

Language Preference: English Spanish Other:_____________________________

B. Service and Provider Information

Type of Service (select one):

Lab Radiology/X-ray/Imaging

Provider Visit Emergency/Urgent Care

Other (please specify):_____________________________________

Date of Service:______________ Client's Out of Pocket Cost Amount:_____________________

Provider Name:____________________________ Phone Number:_______________________

Fax number:_______________________________

C. Enrollment Worker Information

Name:_______________________ Phone Number:_______________ Email:_________________________

D. Pool Administrators Use Only

Received By:__________________ Date Received:_______________ Date Updated:__________________

Comments by Pool Administrators (Check all that apply):

Approved

PAI Payment Date:_______________ Payment Amount:_______________

PAI Check Number:______________ Check Memo Line:_________________

Denial Reason:____

Pending Reason:____

Appeal Reason:____

Date Received: ____________________ Date Responded:________________