



Insurance Premium Payment Assistance 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.

Fax: (860) 560-8225

Email: CDPH_MBM_Fax@pooladmin.com

Mail: PAI-CDPH, 628 Hebron Ave., Suite 100, 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

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: _____