Print Form

HEALTH INSURANCE CLAIM FORM

SUBMIT ALL CLAIMS TO: Capitol Administrators
P.O. Box 2318
Rancho Cordova, CA. 95741-2318
For Information call (800) 331-5301

Important Instructions

- Use a separate claim form for each member of the family and for each different provider of service (Doctor, Dentist, Lab, etc.)
- Type or print all information.
- Fill out all items completely (where applicable).
- Sign and Date the form in the spaces provided.
- If Capitol is your secondary insurance, attach a copy of the Explanation of Benefits (EOB) from your primary carrier.
- Attach the original itemized bill(s) for the services of this provider (we cannot accept 'Balance Statements', cash register or credit card receipts)

Insured's Name (Last, First, MI)		**Insured's social Security Number**	
Street Address or P.O. Box Number	**City**	**State**	**Zip Code**

Name of Patient (Last, First, MI)	**Patient's Gender** ◯ Male ◯ Female	**Date of Birth**
Briefly describe the illness or injury, and if injury, how and when it occured		
Is the condition employment related? ◯ Yes ◯ No	**Name of Provider of Service for this claim**	

Does Patient have other insurance? ◯ Yes ◯ No	**If Yes, Please Complete the Following Sections**
Name of Insurance Plan:	**Policy Number:**
Address of Insurance Plan:	**Name and Date of Birth of Policy Holder:**
Type of Plan: ☐ Group ☐ Individual	**If Group, Name of Employer:**

Insured's Signature

I certify that the foregoing information is accurate and complete, and I authorize the release of any medical information necessary to process this claim.

Signature _____ **Date** _____