CFHC Trust Behavioral Health Program
DRAFT - Behavioral Health Claim Form

Section I – Employer Information

Employer Legal Name:
Employer Address:
HR Contact Name (To anonymously gather any information on program benefits not provided as requested below):
HR Contact Email:
HR Contact Phone:
Employer ID Badge (attach a copy of current fire department badge):
Copy of Employer provided EAP or Behavioral Health Benefit Plan (please provide a website link or a PDF copy of the entire plan, summaries are also helpful):
Contact Information of Insurer or Administrator:

Section II –Individual Participant Information

Individual Participant Name:
Individual Participant Mailing Address:
Individual Participant Social Security Number:
Your Benefit Plan Individual Statement of Benefits:
Individual Participant Phone Number:
Individual Participant Email:
Occupation:
Date of Hire:
Significant Event contributing to Behavioral Health issues being treated:
Have all EAP benefits been applied for and received? If the Participant has EAP benefits, but has not applied or received services, please explain.
Please provide documentation or Explanation of Benefits (EOB):

Section III – Behavioral Health Clinician Information

Clinician Name:
Clinician Address:
Clinician Dates of Service:
Type of Care Clinician Provided:
Total Out of Pocket Cost (attach receipts from clinician):
Explanation of Benefits (EOB) received concerning these charges):

Section IV – Fraud Warning Statement (to be signed by Individual Participant)

Any person who knowingly and with intent defrauds the Trust or other person files an application for the Behavioral Health Program or statement of claim containing any materially false information or conceals, for the purpose of misleading information concerning any fact material thereto commits a fraudulent act, which is a crime and subjects such person to criminal and civil penalties.

I hereby certify the foregoing statements made by me on this form to be true to the best of my knowledge. I am aware that if any of the foregoing statements on this form made by me are willfully false, I may be subject to penalties, which may include criminal prosecution.

Signature of Manager	Name of Manager (please print) Date Signed
Signature of Participant	Name of Participant (please print) Date Signed

Section V – Authorization to Obtain and Disclose Information

To: Any health care provider, employer, benefit plan, insurer, financial institution, consumer reporting agency, educational institution, or Federal, State, or Local Government Agency, including the Social Security Administration and Veterans Administration. I authorize you to disclose to the Trust's Claims Adjusters at Sedgwick Claims Management Services, P.O. Box 14493, Lexington, KY 40512-4493, a complete copy of any and all of the following personal or privileged information, records, or documents relative to:

Participant's Name (please print) Date of Birth Last 4 Digits of SSN

Any and all medical information or records, including x-ray films, medical histories, physical, mental or diagnostic examinations, and treatment notes, alcohol or drug abuse, and mental health, as such information may be related to my claim for the Behavioral Health Program; work information and history, including job duties; information on any insurance coverage, claims filed, and/or services received, including all records and information related to such coverage and claims. The information obtained by use of this Authorization will be used for the purpose of evaluating and administering my claim for an Award under my Employer Provided Behavioral Health Program. Such information shall be referred to herein collectively as "My Information." I understand that I have the right to revoke this Authorization for future disclosures, except to the extent action has been taken in reliance upon this Authorization. I must revoke this Authorization in writing directly to the Trust's Claims Administrators at Sedgwick Claims Management Services.

I ALSO UNDERSTAND that once My Information has been disclosed to the Trust/Sedgwick Claims Management Services as permitted under this Authorization, it may be re-disclosed by the Trust/Sedgwick Claims Management Services as permitted by law or my further authorization. I authorize the Trust/Sedgwick Claims Management Services to use or disclose My Information (i) to my employer for: a) functions related to accommodating my disability; b) responding to claims related to accommodation or adverse or discriminatory treatment related to my claim; c) responding to any litigation or agency charge document production request or lawful subpoena; d) federal or state Family & Medical Leave Act administration; e) matters relating to its workers' compensation arrangements; or f) fulfilling fiduciary obligations under my benefit plan; (ii) to the administrator or other service providers of my employer's benefit plan or other benefit plans of my employer for plan-related functions; (iii) to any claim system used for claims processing or insurance broker to carry out functions related to my benefit plan or claim; (iv) to any health care professional who has treated or evaluated me or who may do so; (v) to other persons or entities performing business or legal services related to my claim; vi) to my employer's workers' compensation insurance

carrier or administrator; (vii) as may be lawfully required; or (viii) as may be necessary to prevent or detect perpetration of a fraud.

I understand that information disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient. I understand that I have the right to revoke this Authorization for future disclosures that the Trust/Sedgwick Claims Management Services may make unless the Trust/Sedgwick Claims Management Services has taken action in reliance upon this Authorization. I must revoke this Authorization in writing directly to the Trust/Sedgwick Claims Management Services. I understand that my medical treatment or payment for medical benefits cannot be conditioned on my allowing the Trust/Sedgwick Claims Management Services to re-disclose My Information. The authorizations set forth herein expire two years from the date listed below, or upon my revocation, if earlier, but will not exceed my eligibility and the term of the Behavioral Health Program Plan Document, except as may be necessary to prevent or detect perpetration of a fraud. I understand that I am entitled to receive a copy of this Authorization upon request. A photocopy or facsimile of this Authorization shall be as valid as the original. If there is a conflict between a prior request for restriction on the disclosure of My Information and this Authorization, this Authorization will control.

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Name of Participant (please print)

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Signature of Participant Date Signed

The Trust provides claim administration service through Sedgwick Claims Management Services.