CLAIM HISTORY COVER SHEET

Dear Employee,

So that we may properly credit deductibles, or other maximums that you and each of your covered dependents satisfied while covered under the prior carrier, we need copies of the prior carrier Explanation of Benefit (EOB) statements.

Note: In order to ensure prompt and accurate claim processing, this information is needed as soon as possible.

If the most recent EOB for you and each dependent includes the total amount satisfied during the benefit year, we will only need copies of those EOBs. If however, the EOBs only show the amount satisfied on each claim, we will need copies of all EOBs for the benefit year so that we may have complete information.

After you have gathered the EOBs, please complete the information below and mail it, along with the EOBs, to the following address:

Neighborhood Health Partnership
Attention: Enrollment Department
1300 River Drive
Moline, IL 61265

Employer Name: ____

Group Number (if available): ____________________________________

Employee Name: ____

Employee Address: ____

____

Nine Digit Member ID Number: ________________________________

(List names of those that you are providing EOBs for. If yourself, check “Yes” next to “Self” below.):

Self: **Yes** ______ **No** _______

Dependent Name:____

Dependent Name:____

Dependent Name:____

Dependent Name:____

Dependent Name:____