5% Max Claim Form

My out-of-pocket maximum is: _____

CHIP: (801) 538-9004 or 1-866-772-1261

Parent/Guardian Name: _____ Case Number: _____

Health Insurance Company: _____

Use this form to keep track of your children's medical services to show you have reached your out-of-pocket maximum. Once this is met, submit this form to the Children's Health Insurance Program. Complete one line for each copayment or coinsurance you incur. Attached are extra claim form pages if you run out of space. Receipts do not need to be submitted, but keep them for your records.

Claim forms may be submitted up to one year following the end of the plan year in which the expenses are incurred. The plan year is July 1 – June 30.

Name of Child	Date of Visit	Did you pay this bill?	Name and mailing address of health-care provider	Amount of copay or coinsurance

Grand Total: _____ Page 1 of _____ Total amount of this page: _____

Send the claim form(s) to:

Children's Health Insurance Program, Box 144102, Salt Lake City, Utah 84114-4102