CHESTERFIELD RESOURCES, INC.
EMPLOYEE HEALTH PLAN CLAIM SUBMISSION FORM

*Note: This claim form is for claims that are being **mailed** to Chesterfield Resources. If you are submitting a claim online at www.chesterfieldresources.com (recommended), you do not need a claim form.*

INSTRUCTIONS:

- Check the type of claim in the box indicated, and complete all sections of the form below.
- Include a copy of the itemized bill from the service provider
  - Please note: For vision claims, you MUST include a copy of a fully paid, itemized receipt.
- Submit this form and the itemized bill to:

Chesterfield Resources
P.O. Box 1884
Akron, OH 44309

PLEASE PRINT OR TYPE; ALL FIELDS ARE REQUIRED

Please submit only ONE claimant per claim form.

Type of Claim: ☐ Medical ☐ Dental ☐ Vision ☐ Hearing

Enrollee's Name	**Date of Birth**	**ID #**	**Group #**

Home Address* Number Street	**City**	**State**	**Zip Code**

Claimant/Patient's Name	**Gender**	**Date of Birth**	**Relationship to Enrollee**
	☐ M ☐ F		☐ Self ☐ Spouse ☐ Child

**If this is a new address, please contact your Benefits Administrator at The Salvation Army to have your address updated prior to submitting your claim to Chesterfield Resources.*

AUTHORIZATION TO PAY PROVIDER (NOTE: DOES NOT APPLY TO REIMBURSEMENTS TO THE CLAIMANT)

Sign here **only** if benefits are to be paid directly to the physician, hospital, or other provider of care.

I authorize payment of benefits to the physician or supplier for service described on the attached bill.

_____ _____

Signature Date