CONSOCIATE HEALTH

105/HRA Claim Form

Employer Name: _____

Employee's Name: _____

Member ID Number: _____

Dependent's Name (if applicable): _____

Date of Service: _____

Provider: _____

Amount Requested: _____

Filing Instructions:

When filing a claim, you **must** attach copies of the Explanation of Benefits (EOB). Please be sure to number each attachment page (i.e., Page 2 of 3, Page 3 of 3, etc.)

If you choose to **mail** your claim with the EOB, *remember to keep a copy of the claim form and supporting documents for your records.*

MAIL TO: **Consociate**
2828 North Monroe Street
P.O. Box 1068
Decatur, Illinois 62526-1068

If you choose to **fax** your claim with the EOB, please **do not** follow-up with a hard copy in the mail.
Remember to keep the original claims form and supporting documents for your records.

FAX TO: **217.233.2281**