EPISCOPAL CHURCH MEDICAL TRUST

Colleague Group Claim Reimbursement Form

Guidelines for Submitting Colleague Group Claims:

- This form is only for the submission of charges related to Colleague Group Benefits.
- SSN and date of birth must be included.
- Attach any claims forms, receipts, or invoices to substantiate dates of service and fee charged.
- **Payment is to reimburse Member**.

Colleague Group Benefit: The colleague group benefit is available to employees and spouses for a total of 24, 90-minute sessions per year per family. Participants may use up to 12 of the 24 colleague group sessions for individual consultation. The plan will cover 70% to the maximum reimbursable fee (MRF) of $40.00. For example, if you participate in a colleague group and your facilitator charges $75.00 a session, the plan will reimburse $40.00 (70% of $75.00 is $52.50, but the MRF is $40.00). Member will be responsible for the remaining charges.

Return this form to: The Episcopal Church Medical Trust, PO Box 2745, New York, NY, 10163; or fax to (212) 251-8891 (confidential fax).

A. PATIENT INFORMATION:

Last Name	First Name	MI	Date of Birth

SSN	Phone

Home Address (Address, City, State, Zip)

B. PROVIDER INFORMATION:

Provider Name	Provider Tax ID	Provider License #

Provider Address, City, State, Zip	Provider Phone

Provider Signature

C. CLAIM INFORMATION

Description/Procedure Codes	Date of Session	Charges	Reimbursement (70% of charges to a MRF of $40)
Colleague Group CPT: 99199 Diagnosis: 799.9			
Colleague Group CPT: 99199 Diagnosis: 799.9			
Colleague Group CPT: 99199 Diagnosis: 799.9			
Colleague Group CPT: 99199 Diagnosis: 799.9			
Colleague Group CPT: 99199 Diagnosis: 799.9			
Colleague Group CPT: 99199 Diagnosis: 799.9			
Colleague Group CPT: 99199 Diagnosis: 799.9			
Colleague Group CPT: 99199 Diagnosis: 799.9			
Total Reimbursement Requested:			

D. THE EPISCOPAL CHURCH MEDICAL TRUST AUTHORIZATION

Signature: _____ Date: _____