



CONSOCIATE • DANSIG

105/HRA CLAIM FORM

EMPLOYER'S 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 DANSIG
 151 E. DECATUR ST.
 P.O. BOX 1068
 DECATUR, IL 62525-1068

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