CarePlus CLAIMS TRANSMITTAL COVER SHEET

This form should be utilized when you have paid a provider up front for services covered under the CarePlus program or for services the provider is not submitting on your behalf. Some examples are childbirth classes, doula services, and service animals. Complete the entire form, attach all supporting documentation then attach your itemized bills/receipts.

Mail or fax completed form and all supporting documentation to:

Mail to:
AT&T CarePlus Program
PO Box 30886
Salt Lake City, UT 84130

OR:

Fax to:
(888) 369-0957

EMPLOYEE INFORMATION:

Employee Name: _____

Member ID: _____ Date of Birth: _____

Employee Address: _____
City/State/Zip

_____

Preferred Phone Number: (_____)_____
Area Code Number

PHYSICIAN/HEALTHCARE PROVIDER INFORMATION:

Provider Name: _____

Provider Address: _____
City/State/Zip

_____

Tax Identification Number (TIN): _____

Contact Person: _____

Contact Person's Phone Number: (_____)_____
Area Code Number

.

Member Signature: _____ **Date:** _____

ANY PERSON WHO KNOWINGLY FILES A STATEMENT OF CLAIM CONTAINING ANY MISREPRESENTATION OR ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION MAY BE GUILTY OF A CRIMINAL ACT PUNISHABLE UNDER LAW AND MAY BE SUBJECT TO CIVIL

.