**FAX COVER SHEET**
**TO FIRST SERVICE ADMINISTRATORS, INC.**

**No of Pages Sent (including this cover sheet):**_____

**FAX TO: 888.531.2804** (vision, dental, and out-of-network medical provider statements or receipts)

Email address for *confirmation purposes only* _____
**(*please allow 72 hours prior to calling for status of faxed claim*)**

Statements or receipts may be submitted directly to First Service Administrators, Inc. for processing; ***please confirm by checking the following information is clearly identified on the statement/receipt:***

- ❑ Provider Name
- ❑ Provider Address and Tax Identification Number (for vision, dental, and out-of-network medical provider statements or receipts)
- ❑ Member Name
- ❑ Patient Name (if different from member)
- ❑ Date of Service
- ❑ Service(s) Provided
- ❑ Billed charges for service(s)
- ❑ Primary Insurance Explanation of Benefits is included (if CCSO is secondary payor, not primary)

*Please note:*

- Proof of method of payment (charge card receipts, cancelled checks, etc.) are ***not*** required. If your receipt/statement contains all of the above information, there is no need to fill out any additional forms.
- You do not need to submit statements or receipts for any in-network medical providers. You should only submit statements or receipts for Vision, Dental or Out-of-Network providers. In -network medical providers are required to submit a claim on your behalf directly to First Service Administrators.
- Keep copies of supporting documentation for your records. We cannot return what has been submitted.

Submitted by:_____ Date:_____
(Print Name)

Signature:_____

Medical Plan ID Number:_____ Contact Phone Number:_____