State of California Health and Human Services Agency California Department of Public Health

Medical Out-of-Pocket Claim Form

Submitter must complete Sections A and B. This claim form AND supporting documentation (Explanation of Benefits and an invoice) must be sent to Pool Administrators, Inc. (PAI). If you have any questions about submitting this form, please contact PAI Customer Service at (877) 495-0990.

Electronically: Payer ID: PAI02
Fax: (860) 560-8225
Email: CDPH_MBM_Fax@pooladmin.com
Mail: PAI-CDPH, 628 Hebron Ave., Suite 502, Glastonbury, CT 06033

A. Client Information

First Name:_____ Last Name:_____

Date of Birth:_____ Client ID number:_____

Client Mailing Address:_____

City:_____ State:_____ Zip Code:_____

B. Service and Provider Information

Date of Service:_____ Client's Out of Pocket Cost Amount:_____

Provider Name:_____ Phone Number:_____

Type of Service (select one):
N/A for PrEP or Injectable Medication Claim Submissions

- ☐ Lab
- ☐ Radiology/X-ray/Imaging
- ☐ Provider Visit
- ☐ Other (please specify):_____
- ☐ Emergency/Urgent Care
- ☐ Dental
- ☐ Vision

C. Enrollment Worker Information

Name:_____ Phone Number:_____ Email:_____

For faster processing please be sure to include all supporting documentation (Explanation of Benefits and an invoice) along with this claim form to PAI.