Culinary Health Fund
Administrative Services, LLC

ADDITIONAL INFORMATION SUBMISSION FORM

DATE: _____

CLAIM #: _____

MEMBER ID#: _____

PATIENT NAME: _____

DATE OF SERVICE: _____

PROVIDER TIN: _____

PROVIDER NAME: _____

CONTACT PERSON: _____

PHONE NUMBER: _____

ATTACHMENTS: Check all that apply

☐ Copy of Claim ☐ Operative Report ☐ Medical Records
☐ Primary Insurance EOB ☐ Itemization

☐ Other _____

Culinary Health Fund
P.O. Box 211471
Eagan, MN 55121