Manual Claim Submission Form

Group Name: ____

Policyholder (Employee) Name: ____________________________________

Identification Number of Policyholder:____

Patient Name: ____

Phone number we can call in case of questions: _________________________

Date of Service: _________________________**Amount paid to your provider:**_____________

Provider Name: ____

Provider FEIN/Tax ID Number: ______________________________________

Diagnosis Code: ______________________ **CPT/Procedure Code:** _______________________

Brief description of services rendered: ____

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Please attach:

- A receipt showing proof of payment made to your provider, if applicable.
- An itemization or claim form your provider's office may have given you, if available.

Submit your request either by fax or mail to:

Fax: 608.273.4554 or Mail:
Auxiant
Attn: Claims Department
P.O. Box 259710
Madison, WI 53725-9710

Auxiant will apply all standard benefits applicable to the services provided including Deductible, coinsurance, copays, provider discounts (if applicable), etc. Please allow 10-15 business days for your claim to be processed.

Auxiant®
Independent Solutions › Real Results