Colorado Firefighter Heart, Cancer, and Behavioral Health Trust
Behavioral Health Claim Form

Section I – Employer Information

Employer Legal Name	
Employer Address	HR Contact Name (To anonymously gather any information on program benefits not provided as requested below):
HR Contact Email	HR Contact Phone Number
(attach a copy of current fire department badge)	
Name of Employer Assistance Program (EAP) or Employer Behavioral Health Program	
Copy of Employer provided EAP or Behavioral Health Benefit Plan (please provide a website link or a PDF copy of the entire plan, summaries are also helpful)	
Contact Information of Employer Provided Behavioral Health Program (for example, the EAP Insurer or Behavioral Health Benefit Plan Administrator)	

Section II – Individual Participant Information

Individual Participant Name	
Individual Participant Date of Birth	Individual Participant Social Security Number
Individual Participant Mailing Address	Individual Participant Employment Type Full-Time ☐ Part-Time ☐ Volunteer ☐
Individual Participant Phone Number	Individual Participant Email
Job Title	Date Of Hire
Significant Event contributing to Behavioral Health concerns being treated	Date of Incident (When initial Care Started and not prior to 2/10/23)

Have all employer provided coverage, programs, or services, including any employee assistance program (EAP) benefits or Employer Provided Behavioral Health Program been applied for and received? Yes ☐ No ☐

If no, please explain below, or attach a separate letter of explanation.

Please provide an invoice from clinician or Explanation of Benefits (EOB) for the Employer Provided Behavioral Health Program (Statements are not accepted):

Section III – Behavioral Health Clinician Information

Clinician Name:

Clinician Address:

Clinician Dates of Service:

Type of Care Clinician Provided	Total Out of Pocket Cost (attach receipts from clinician)

Did your behavioral health clinician prescribe any medication to assist in your treatment? If yes, please provide a copy of the prescription receipt for reimbursement. Yes ☐ No ☐

Section IV – Fraud Warning Statement (to be signed by Individual Participant)

Any person who knowingly and with intent defrauds the Trust or other person files an application for the Behavioral Health Program or statement of claim containing any materially false information or conceals, for the purpose of misleading information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

I hereby certify the foregoing statements made by me on this form to be true to the best of my knowledge. I am aware that if any of the foregoing statements on this form made by me are willfully false, I may be subject to penalties, which may include criminal prosecution.

Signature of Participant	Name of Participant (please print)	Date Signed

Your completed claim form can be sent to the Trust Administrator at:

Colorado Firefighter Heart, Cancer, and Behavioral Health Benefits Trust c/o McGriff Insurance Services
P.O. Box 1539 | Portland, OR 97207
Email: claims@cfhtrust.com
Fax: 503-598-8523