

# HEALTH BENEFITS CLAIM FORM



PLEASE COMPLETE A SEPARATE CLAIM FORM FOR EACH FAMILY MEMBER.  
(SEE REVERSE SIDE FOR FILING INFORMATION)

PLEASE COMPLETE EACH NUMBERED ITEM - FAILURE TO DO SO MAY RESULT IN DELAYS IN PROCESSING YOUR CLAIM

**PLEASE TYPE OR PRINT**

1. IDENTIFICATION NUMBER	2. GROUP NUMBER OR ENROLLMENT CODE	3. PATIENT'S NAME (FIRST, MIDDLE INITIAL, LAST)
4. PATIENT'S DATE OF BIRTH MO DAY YEAR / /	5. PATIENT'S SEX FEMALE <input type="checkbox"/> MALE <input type="checkbox"/>	6. PATIENT'S RELATIONSHIP TO SUBSCRIBER: EE SP CH SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER <input type="checkbox"/> EXPLAIN: _____
7. SUBSCRIBER'S NAME (FIRST, MIDDLE INITIAL, LAST)		8. DAYTIME TELEPHONE NUMBER (INCLUDE AREA CODE) ( ) -
9. SUBSCRIBER'S ADDRESS (STREET, CITY, STATE, ZIP CODE) CHECK IF NEW ADDRESS <input type="checkbox"/>		

10. IS PATIENT COVERED UNDER OTHER HEALTH INSURANCE? NO  YES  IF YES, NAME OF OTHER INSURANCE COMPANY \_\_\_\_\_  
NAME OF POLICY HOLDER \_\_\_\_\_ POLICY OR IDENTIFICATION NUMBER \_\_\_\_\_

IS PATIENT COVERED UNDER MEDICARE? NO  YES  IF THE SUBSCRIBER IS MARRIED, IS THE SPOUSE EMPLOYED? NO  YES   
IF YES, PART A  PART B  MEDICARE HIC NUMBER \_\_\_\_\_ IF YES, GIVE THE NAME OF THE SPOUSE'S EMPLOYER ⚡ \_\_\_\_\_

IS PATIENT ACTIVELY EMPLOYED? NO  YES  IF YES, NAME OF EMPLOYER ⇄ \_\_\_\_\_

11. WAS PATIENT'S CONDITION DUE TO: AUTO ACCIDENT? NO  YES  ANY OTHER ACCIDENTAL INJURY? NO  YES  WORK RELATED ACCIDENT OR CONDITION? NO  YES   
MEDICAL EMERGENCY? NO  YES  IF AN ACCIDENT, GIVE THE DATE OF THE ACCIDENT MO DAY YEAR / / WAS ANOTHER PARTY AT FAULT? NO  YES   
IF MEDICAL EMERGENCY GIVE DATE SYMPTOMS BEGAN MO DAY YEAR / / **IF YES, ATTACH A STATEMENT WITH DETAILS (SEE ACCIDENTAL INJURY ON THE REVERSE SIDE)**

12. WAS PATIENT HOSPITALIZED? NO  YES  IF YES, COMPLETE THE FOLLOWING: NAME OF HOSPITAL \_\_\_\_\_  
ADMISSION DATE MO DAY YEAR / / DISCHARGE MO DAY YEAR / / NAME & ADDRESS OF ADMITTING PHYSICIAN \_\_\_\_\_

13. ARE BILLS FOR A CONSULTATION ATTACHED? NO  YES  IF YES, GIVE NAME OF PHYSICIAN WHO REQUESTED THE CONSULTATION \_\_\_\_\_  
WAS THE CONSULTATION REQUESTED TO OBTAIN A SECOND SURGICAL OPINION? NO  YES   
WAS SURGERY RECOMMENDED? NO  YES

14. ARE BILLS FOR MATERNITY ATTACHED? NO  YES  IF YES, WHAT IS THE DATE OF THE LAST MENSTRUAL PERIOD? MO DAY YEAR / /

15. STATE THE DIAGNOSIS, SYMPTOMS, ILLNESS OR INJURY FOR THE EXPENSES CLAIMED  
HAS PATIENT HAD THESE SYMPTOMS/CONDITION BEFORE? NO  YES  IF YES, WHEN MO DAY YEAR / /  
GIVE DATE SYMPTOM(S) FIRST STARTED MO DAY YEAR / /  
GIVE DATE PHYSICIAN FIRST SEEN MO DAY YEAR / /

16. LIST BELOW ONLY THOSE CHARGES BEING CLAIMED AND ATTACH ORIGINAL ITEMIZED BILLS FROM THE PROVIDERS FOR THESE SERVICES

NAME(S) OF PROVIDER(S)	DESCRIPTION(S) OF SERVICE(S)	DIAGNOSIS (IF MORE THAN ONE)	FROM DATE			TO DATE			CHARGE
			MO	DAY	YEAR	MO	DAY	YEAR	
A.			/	/	/	/	/	/	\$ .
B.			/	/	/	/	/	/	\$ .
C.			/	/	/	/	/	/	\$ .
D.			/	/	/	/	/	/	\$ .

17. **TOTAL** \$ ,

**18. THIS CLAIM FORM MUST BE SIGNED. IF NOT, IT WILL BE RETURNED.**

I request benefits for these expenses and certify that the above information is correct and that the foregoing expenses were incurred for the above named patient. I authorize any physician, nurse, hospital or other providers or suppliers in possession of information concerning the patient to furnish such information to CareFirst BlueCross BlueShield upon request.

Subscriber Signature \_\_\_\_\_ Date MO DAY YEAR / /

Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

### AUTHORIZATION FOR ASSIGNMENT OF BENEFITS (SEE REVERSE)

I, the undersigned, authorize CareFirst BlueCross BlueShield to make payment for benefits due herein to

Name of Provider \_\_\_\_\_

Provider's Tax or Social Security Number \_\_\_\_\_

Name of Provider \_\_\_\_\_

Provider's Tax or Social Security Number \_\_\_\_\_

Subscriber Signature \_\_\_\_\_ Date MO DAY YEAR / /

# INSTRUCTIONS

**THIS FORM IS TO BE USED TO SUBMIT A CLAIM FOR SERVICES UNDER YOUR HEALTH PLAN. TO AVOID HAVING YOUR CLAIM RETURNED:**

- ✓ PREPARE A **SEPARATE CLAIM FORM** FOR EACH FAMILY MEMBER.
- ✓ COMPLETE **ALL OF THE INFORMATION REQUESTED** IN ITEMS 1 THRU 18.
- ✓ IF YOU PREFER THAT **BENEFITS BE PAID TO THE PROVIDER OF SERVICE BE SURE TO COMPLETE THE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS ON THE FRONT.** CAREFIRST BLUECROSS BLUESHIELD RESERVES THE RIGHT TO MAKE PAYMENT DIRECTLY TO THE SUBSCRIBER AND TO REFUSE TO HONOR THE ASSIGNMENT OF ANY CLAIM TO ANY PERSON OR PARTY.

**EACH PROVIDER'S ORIGINAL ITEMIZED BILL MUST BE ATTACHED AND CONTAIN:**

- ✓ THE LETTERHEAD INDICATING THE NAME AND ADDRESS OF THE PERSON OR ORGANIZATION PROVIDING THE SERVICE
- ✓ THE DATE FOR EACH INDIVIDUAL SERVICE (A RANGE OF DATES CANNOT BE ACCEPTED)
- ✓ THE CHARGE FOR EACH INDIVIDUAL SERVICE
- ✓ A DESCRIPTION OF EACH SERVICE
- ✓ THE NAME OF THE PATIENT RECEIVING THE SERVICE

**ON EACH BILL, PLEASE CROSS OUT ANY CHARGES THAT WERE INCLUDED ON A PREVIOUS CLAIM. PERSONAL ITEMIZATIONS, CASH REGISTER RECEIPTS, CREDIT CARD RECEIPTS AND CANCELLED CHECKS ARE NOT ACCEPTABLE. ITEMIZED BILLS CANNOT BE RETURNED.**

**IN ADDITION TO THE ABOVE REQUIREMENTS, THE FOLLOWING INFORMATION WILL BE NEEDED:**

**ACCIDENTAL INJURY** - STATEMENTS MUST CONTAIN DETAILS AS TO WHEN, WHERE AND THE MANNER IN WHICH THE INJURY OCCURRED, AS WELL AS THE NAME AND ADDRESS OF THE PARTY AT FAULT.

**PRESCRIPTION DRUGS** - BILLS MUST INCLUDE THE PRESCRIPTION NUMBER, THE NAME OF THE DRUG AND THE NAME OF THE PHYSICIAN PRESCRIBING THE MEDICATION.

**PRIVATE DUTY NURSING** - BILLS MUST INCLUDE THE SHIFT WORKED, THE CHARGE PER HOUR, THE NUMBER OF HOURS WORKED, THE NURSE'S PROFESSIONAL STATUS, PROFESSIONAL LICENSE NUMBER AND FAMILY RELATIONSHIP TO THE PATIENT, IF ANY. A STATEMENT FROM THE ATTENDING PHYSICIAN MUST ACCOMPANY THE CLAIM. THE STATEMENT SHOULD EXPLAIN THE MEDICAL NECESSITY OF THE SERVICE AND THE AUTHORIZATION FOR IT.

**PROSTHETIC APPLIANCES AND THE RENTAL OR PURCHASE OF DURABLE MEDICAL EQUIPMENT** - A STATEMENT FROM THE ATTENDING PHYSICIAN MUST ACCOMPANY THE CLAIM. THE STATEMENT SHOULD EXPLAIN THE MEDICAL NECESSITY OF THE EQUIPMENT AND THE PHYSICIAN'S AUTHORIZATION FOR IT.

**PSYCHOTHERAPY** - BILLS MUST INCLUDE THE LENGTH OF THE SESSION, THE TYPE OF SESSION AND THE PROVIDER'S PROFESSIONAL STATUS. IF THE PROVIDER IS OTHER THAN A MEDICAL DOCTOR, THE PROVIDER'S PROFESSIONAL LICENSE NUMBER MUST ALSO BE GIVEN.

**FOR PATIENTS COVERED BY ANOTHER INSURANCE CARRIER OR MEDICARE** - IF THE PATIENT IS CLAIMING BENEFITS FOR ANY CHARGES THAT ARE ELIGIBLE FOR BENEFITS UNDER ANY OTHER HEALTH INSURANCE POLICY OR MEDICARE PART A AND/OR PART B, THE EXPLANATION OF BENEFITS FORM FURNISHED BY THE OTHER CARRIER PERTAINING TO THESE CHARGES MUST BE INCLUDED WITH THE ITEMIZED BILLS. A CLEAR PHOTOCOPY OF THE OTHER CARRIER'S EXPLANATION OF BENEFITS FORM IS ACCEPTABLE IN PLACE OF THE ORIGINAL DOCUMENT.

**BEFORE SUBMITTING YOUR CLAIM, PLEASE BE SURE THAT:**

1. THE CLAIM FORM IS FULLY COMPLETED AND SIGNED.
2. THE ITEMIZED BILLS ARE ATTACHED.
3. YOU HAVE KEPT COPIES OF EACH DOCUMENT AND BILL FOR YOUR PERSONAL RECORDS

**THE CLAIM FORM AND ALL RELATED MATERIALS SHOULD BE SUBMITTED TO:**

CAREFIRST BLUECROSS BLUESHIELD  
MAIL ADMINISTRATOR  
P.O. BOX 14116  
LEXINGTON, KY 40512-4116