HEALTH INSURANCE CLAIM FORM

Please Print Clearly (See Reverse For Instructions)

SUBSCRIBER INFORMATION (Person whose name is on contract.)

1) Subscriber's Last Name | First Name | Middle Initial

2) Daytime Telephone Number ( )

3) Identification Number (IID) - Including Alpha Prefix

4) Group Number

5) Subscriber's Address, Number and Street | City | State | Zip

6) Employer's Name (Group Name if applicable)

7) Check here if new address ☐

PATIENT INFORMATION (Use a separate form for each patient.)

8) Patient's Last Name | First Name | Middle Initial

9) Date of Birth

10) Sex ☐ Male ☐ Female

11) Patient is (check one): ☐ Subscriber (contract holder) ☐ Spouse (of contract holder) ☐ Child ☐ Other (specify) ____________

12) Patient Enrolled in (If yes, give Identification Number and Effective Date)

Medicare Part A (Hospital)? ☐ No ☐ Yes

Medicare Part B (Medical)? ☐ No ☐ Yes

Other Blue Cross & Blue Shield Membership? ☐ No ☐ Yes

Other Health Insurance Plan? ☐ No ☐ Yes

Identification Number: ______________________________

Effective Date: ______________________________

13) Was Treatment for:

			Date of Accident
Accident at Work	☐ No	☐ Yes	____/____/____
Other Accident	☐ No	☐ Yes	____/____/____

Name of Policyholder: ______________________________

Name of Other Insurance: ______________________________

Address of Other Insurance: ______________________________

Please attach a copy of the Explanation of Benefits from Other Insruance Carrier.

CLAIM INFORMATION

Dates of Service From Mo. Day Yr.	To (Discharge) Mo. Day Yr.	Description of Service	Provider Name	Description of Illness	Amount Charged

Total No. of Bills Attached: ____________ Total Charges $____________

14) I certify the above information is correct and that charges were incurred by the above named patient.

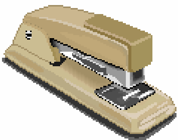
____

(Signature) (Date)

Health Insurance Claim Form Instructions

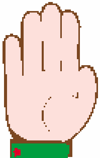
A. Before filling out this form please complete the following in order to ensure timely processing of your claim.

- Check with your doctor, hospital, or pharmacy to ensure that these charges have not already been submitted.
- Review your bill in order to determine which charges are to be considered.
- Please submit charges for only one calendar year per claim form.
- Please submit charges for only one patient per claim form.



B. Attach ITEMIZED BILLS to this completed claim form. Cross off any charges which have already been submitted for processing. Each attached bill must show:

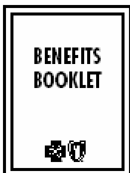
- Name and address of physician, pharmacy, or other provider of service; and Tax ID number of provider.
- Name of patient; IID of employee, including alpha prefix.
- Description of service OR pharmacy prescription number and drug name.
- Date each service was rendered/performed.
- Amount charged for each service.
- Diagnosis.



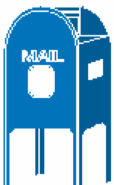
DO NOT SUBMIT CANCELED CHECKS, CASH REGISTER RECEIPTS, OR STATEMENT SHOWING "BALANCE DUE" ONLY.

C. KEEP A COPY OF ALL BILLS FOR YOUR RECORDS.

D. Attach a copy of any explanation of benefits (EOB) you have received from another group health insurance plan or Medicare for the same medical service.



E. IF YOU HAVE ANY QUESTIONS REGARDING YOUR BENEFITS PLEASE REFER TO YOUR BENEFIT BOOKLET.



F. MAILING ADDRESS CAN BE OBTAINED BY CALLING 1-800-487-8322.