HEALTH INSURANCE CLAIM FORM Send Completed Claim Form To: Blue Cross and Blue Shield of Illinois P.O. Box 805107 CHICAGO, IL 60680-4112

PLEASE PRINT OR TYPE CLEARLY

NOTICE TO ALL PARTIES COMPLETING THIS FORM: It is fraudulent to fill out this form with information you know to be false or to omit important facts. Criminal and/or civil penalties can result from such acts.

ID NUMBER Copy this from your Blue Cross and Blue S	Shield Identification	n Card.				
GROUP NUMBER:		IDENTIFICAT	ION NUMBI	ER:		
PATIENT INFORMATION A separate claim form must be	completed for ea	ich family me	mber.			
PATIENT'S FULL LEGAL NAME (Last, First, Middle Initial)	o completed for ea		SEX:	SOCIAL SECURITY N	IUMBER (optional):	DATE OF BIRTH
, , , , ,			□ Male □ Female		/	Month Day Year
PATIENT IS: ☐ Member ☐ Spouse ☐ C	hild OTHE	R, please exp	olain relation	ship:		
IF CLAIM IS FOR CHILD 19 OR OLDER—IS CHILD:	A full-	time student	? 🛘 Yes	□ No Ha	ndicapped?	□ No
PAYEE:						
PATEE:						
☐ MAKE PAYMENT TO THE PROVIDER (hos	pital, doctor et	tc.), <u>OR</u>				
☐ MAKE PAYMENT TO MEMBER , the provid	er has been pa	aid				
MEMBER INFORMATION						
MEMBER (POLICY HOLDER) NAME: (As shown on your BI ID Card)	ue Cross and Blue	Shield	SOCIAL SE	CURITY NUMBER (c	ptional):	DATE OF BIRTH Month Day Year
,				′/		
CURRENT ADDRESS:					HOME PHO	DNE:
'					WORK PHO	DNE:
YOUR EMPLOYER, PROVIDE					()	<u></u>
CLAIM INFORMATION						
IS CLAIM FOR AN ACCIDENTAL INJURY?	IS THIS A WORKE	RS COMPEN	ISATION CL	AIM?	DATE OF ACCID	ENT:
	□ Yes □ No					
BRIEFLY DESCRIBE INJURY:						
COMPLETE BELOW IF NON-ACCIDENTAL INJURY OR IL	LNESS					
				TENT RECEIVED THE	SE SERVICES:	
(You can usually cop	by the diagnosis or	aescription o	of service fro	m the provider bill.)		
OTHER INSURANCE INFORMATION						
Are there any OTHER medical benefits available to you, you		dependents	from OTHEF	R Group Insurance, in	cluding OTHER Blue	Cross and Blue Shield policies
OTHER Employer, Labor or Professional Organizations, Sc ☐ Yes (provide below) ☐ No	nool, etc.?					
POLICY HOLDER NAME:				S	OCIAL SECURITY N	
POLICY HOLDER IS:	□ Child □	OTHER, plea	se explain r	- elationship:	//	
INCLIDANCE CARRIED NAME:			POLIC	V NI IMPED:		EFFECTIVE DATE:
INSURANCE CARRIER NAME:			POLIC	Y NUMBER:		EFFECTIVE DATE:
ADDRESS:					PHONE NU	MBER:
						<u> </u>
ELEASE OF INFORMATION: I certify that the	e above inform	nation is	correct a	nd that the bills	attached were	incurred by the patien
sted above. I understand that Blue Cross an				-		
urnished by me or obtained from other source					dance with the	federal privacy
egulations under HIPAA (Health Insurance P	ortability and	Accounta	ibility AC	1 01 1996).		
ign Iere						Date
Signatur	e of Member				'	a.e

Filing Claims... can be as easy as 1-2-3

1 Most Hospitals and Doctors will file a claim directly with us.

Please show your Blue Cross and Blue Shield identification card to the hospital or doctor. Most providers will file for you.

If you are filing a claim, please fill out the reverse side of this form. Help us avoid unnecessary delays by answering all questions completely.

Help us process your claims quickly...Insist on itemized bills.

We want to process your claims quickly, but we can't do so without properly itemized bills.

HERE'S WHAT WE URGE YOU TO DO:

- 1. Show the following instructions to the persons providing for your health care and ask them for bills that follow these instructions.
- 2. Attach ORIGINAL BILLS to this claim form. We recommend that you make copies of each bill for your personal records. The original bills will not be returned.

Is Medicare Your Primary Health Insurance Payer?

If YES, please be sure to send all bills to Medicare FIRST. (services not covered by Medicare may be sent directly to BlueCross and BlueShield FIRST). After you receive an "EXPLANATION OF BENEFITS" form from Medicare showing what was paid, send a copy of this notification with your medical bills and completed Health Insurance claim form to us for processing.

Itemized Bills for Medical Treatment or Surgery Should Show:

- Physician's name, address and phone number.
- Physician's tax identification number.
- Full name of patient, not just name of person to whom bill is addressed.
- Place where service was received (hospital, office or clinic).
- Diagnosis of illness or injury. If an injury give the date it happened.
- Description of service received.
- Date of each treatment or surgical procedure.
- Charge for each treatment or surgical procedure.

Bill for the Following Services Should Show:

AMBULANCE SERVICE (Check your policy to make sure you are covered for ambulance service):

- Date(s) when service was used.
- Base rate and mileage.
- Place where patient was picked up and driven to.

If transferred from one location to another, a letter from the attending physician giving the reason for the transfer must be attached to the bill.

Rental of Durable Medical Equipment:

A statement from the attending physician stating why the equipment was necessary must be attached to the bill. Also provide an estimate of how long the equipment will be used and the purchase price of the equipment.

If for long term use, please remember RENTAL IS PAID ONLY UP TO THE PURCHASE PRICE OF THE EQUIPMENT.

Private Duty Nursing:

- Bills must show whether the nurse is a registered nurse or a licensed practical nurse.
- Nurse's license or registry number.
- Date(s) of service.
- Type of care given.
- · Charge for each hour or shift.

A letter from the physician stating why nursing care was necessary, as well as the nurses progress notes, must be attached to the nurses bill.

