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 including pharmacists, 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.

2 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 Blue Cross and Blue Shield 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.

Pharmacist Bills Should Show:

- Name and address of pharmacy.
- Full name of patient, not just name of person responsible for payment.
- Date(s) of purchase(s).
- Prescription number(s) and name of drug(s) purchased.
- Separate charge for each prescription.
- Computerized listings must have the pharmacist's signature (or rubber stamp) and license number on each page.

IMPORTANT: CASH REGISTER/CREDIT CARD receipts or LISTINGS made by you of drugs purchased CANNOT BE USED because they do not give the above information. The pharmacist must give you bills with itemized charges plainly written on each bill.

SPECIAL NOTE: You can avoid filing your prescription drug claims and save money by having your pharmacist file using the Blue-Script service. Just show your Blue Cross identification card to the pharmacist, in most cases, he'll do the rest.

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.

BlueCross BlueShield of Illinois

An Independent Licensee of the Blue Cross and Blue Shield Association

3 HEALTH INSURANCE CLAIM FORM

Send Completed Claim Form To:
Blue Cross and Blue Shield of Illinois
P.O. Box 1220
CHICAGO, IL 60690-1220

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 Shield Identification Card.

GROUP NUMBER:	IDENTIFICATION NUMBER:

PATIENT INFORMATION -- A separate claim form must be completed for each family member.

PATIENT'S FULL LEGAL NAME (Last, First, Middle Initial)	SEX: ☐ Male ☐ Female	SOCIAL SECURITY NUMBER: ___ ___ ___/ ___ ___/ ___ ___ ___ ___	DATE OF BIRTH Month / Day / Year

PATIENT IS: ☐ Member ☐ Spouse ☐ Child OTHER, please explain relationship:

IF CLAIM IS FOR CHILD 19 OR OLDER – IS CHILD: A full time student? ☐ Yes ☐ No Handicapped? ☐ Yes ☐ No

PAYEE:

☐ MAKE PAYMENT TO THE **PROVIDER** (hospital, doctor etc.), OR

☐ MAKE PAYMENT TO **MEMBER**, the provider has been paid

MEMBER INFORMATION

MEMBER (POLICY HOLDER) NAME: (As shown on your Blue Cross and Blue Shield ID Card)	SOCIAL SECURITY NUMBER: ___ ___ ___/ ___ ___/ ___ ___ ___ ___	DATE OF BIRTH Month / Day / Year

CURRENT ADDRESS:	HOME PHONE: (___ ___ ___)___ ___ ___-___ ___ ___ ___
IF COVERAGE IS THRU YOUR EMPLOYER, PROVIDE GROUP (EMPLOYER) NAME:	WORK PHONE: (___ ___ ___)___ ___ ___-___ ___ ___ ___

CLAIM INFORMATION

IS CLAIM FOR AN ACCIDENTAL INJURY? ☐ Yes ☐ No	IS THIS A WORKERS COMPENSATION CLAIM? ☐ Yes ☐ No	DATE OF ACCIDENT:

BRIEFLY DESCRIBE INJURY:

*COMPLETE BELOW IF **NON-ACCIDENTAL** INJURY OR ILLNESS*

DATE FIRST TREATED:	BRIEFLY DESCRIBE THE CONDITION(S) FOR WHICH THE PATIENT RECEIVED THESE SERVICES: (You can usually copy the diagnosis or description of service from the provider bill.)

OTHER INSURANCE INFORMATION

Are there any OTHER medical benefits available to you, your spouse, or your dependents from OTHER Group Insurance, including OTHER Blue Cross and Blue Shield policies, OTHER Employer, Labor or Professional Organizations, School, etc.?
☐ Yes (provide below) ☐ No

POLICY HOLDER NAME:	SOCIAL SECURITY NUMBER: ___ ___ ___/ ___ ___/ ___ ___ ___ ___

POLICY HOLDER IS: ☐ Member ☐ Spouse ☐ Child ☐ OTHER, please explain relationship:

INSURANCE CARRIER NAME:	POLICY NUMBER:	EFFECTIVE DATE:

ADDRESS:	PHONE NUMBER: (___ ___ ___)___ ___ ___-___ ___ ___ ___

RELEASE OF INFORMATION: I certify that the above information is correct and that the bills attached were incurred by the patient listed above. I authorize any medical professional, hospital, medical or medically related facility, pharmacy, government agency, insurance company, or other person or firm to provide Blue Cross and Blue Shield information, including copies or records, concerning advice, care or treatment provided the patient above including, without limitation, information relating to mental illness, use of drugs or alcohol, upon presentation of the original copy of this signed authorization. I understand that such information will be used by Blue Cross and Blue Shield for the purpose of evaluating a claim for insurance benefits for services provided to the patient named above. I understand that I or any authorized representative will receive a copy of this authorization upon request. The authorization is valid from the date signed for the duration of the claim.

Sign Here _____ **Date** _____

Signature of Member