Plan 150 Claim Form

BlueCross BlueShield of Kansas*
www.bcbsks.com

NOTE: A separate claim must be submitted for each patient when sending bills.

Section 1

Member Information as it appears on your Blue Cross and Blue Shield of Kansas identification card:

Member Name ______________________________ Identification No. ______________
Last First MI

Member Address ______________________________ Group No. ______________
Street (if applicable)

______________________________ Date of Birth ______________
City State ZIP Code

Is the above a change of address? ☐ Yes ☐ No

Section 2

Patient Information:

Patient Name ______________________________ Date of Birth ______________
Last First MI

Patient Address ______________________________ ☐ Male ☐ Female
Street

____
City State ZIP Code

Relationship to Member: ☐ Self ☐ Spouse ☐ Child ☐ Other

Nature of Illness ______________________________

Diagnosis ______________________________

____

Date of service on bills submitted: Earliest Date ______________ Last Date ______________

Section 3

Physician Information:

Diagnosing Physician Name ______________________________ Phone No. ______________
Last First MI

Physician Address ______________________________
Street

____
City State ZIP Code

Is this the first Plan 150 claim filed for this patient? ☐ Yes ☐ No

Section 4

Report of Services: (attach itemized bill)

Date of Service	Description of surgical or medical services received

Please continue on other side.→

Section 5

General Information:

Claims need to be submitted within one year and 90 days from the date of service.

Preparation of Bills:

All bills must be itemized and attached to the claim form.

NOTE: Cancelled checks, payment receipts or balance forward bills are not acceptable.

Preparation of the Claim Form:

Member Information (things to remember)

- You MUST enter full first and last name, middle initial.
- You MUST enter the correct and complete identification number and group number (if applicable) for the claim to be processed.
- You MUST enter the correct and complete address for mailing of payment.

Patient Information (things to remember)

- Enter FULL name of patient, patient's date of birth, and be sure to check a "Relationship to Member" box.

NOTE: All items must be completed for this claim to be processed.

Mailing Address:

To ensure proper handling, mail this claim to:

Blue Cross and Blue Shield of Kansas
1133 SW Topeka Boulevard
Topeka, Kansas 66629-0001

A new claim form will be mailed to you with your payment.

Customer Service:

Our customer service center personnel are available to answer your questions:

In Topeka: 291-4180

Toll Free: 1-800-432-3990

Authorization to Release Information:

I hereby authorize the diagnosing physician named above to release any information acquired in the course of my examination or treatment.

Patient's signature ______________________________ **Date** ______/______/______

Parent or guardian, if minor