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.

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 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.

BlueCross BlueShield of Illinois

3 HEALTH INSURANCE CLAIM FORM

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

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.

PLEASE PRINT OR TYPE CLEARLY

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 (optional): __ __ __/ __ __/ __ __ __ __	DATE OF BIRTH Month / Day / Year

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

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 (optional): __ __ __/ __ __/ __ __ __ __	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 (optional): __ __ __/ __ __/ __ __ __ __

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 understand that Blue Cross and Blue Shield's use or disclosure of individually identifiable health information, whether furnished by me or obtained from other sources such as medical providers, shall be in accordance with the federal privacy regulations under HIPAA (Health Insurance Portability and Accountability Act of 1996).

Sign Here _____ **Date** _____

Signature of Member