HEALTH BENEFITS CLAIM FORM

CareFirst BlueCross BlueShield

PLEASE COMPLETE A SEPARATE CLAIM FORM FOR EACH FAMILY MEMBER.
(SEE REVERSE SIDE FOR FILING INFORMATION)
PLEASE COMPLETE EACH NUMBERED ITEM - FAILURE TO DO SO MAY RESULT IN DELAYS IN PROCESSING YOUR CLAIM

PLEASE TYPE OR PRINT

*THIS FORM CAN ALSO BE USED FOR FILING CLAIMS FOR CAREFIRST BLUECHOICE OPT-OUT *PLUS*.

1. IDENTIFICATION NUMBER	2.GROUP NUMBER OR ENROLLMENT CODE	3.PATIENT'S NAME (FIRST, MIDDLE INITIAL, LAST)

4. PATIENT'S DATE OF BIRTH	5. PATIENT'S SEX	6. PATIENT'S RELATIONSHIP TO SUBSCRIBER:
MO DAY YEAR ___/___/___	FEMALE ❑ MALE ❑	*EE SP CH* SELF ❑ SPOUSE ❑ CHILD ❑ OTHER ❑ EXPLAIN:

7. SUBSCRIBER'S NAME (FIRST, MIDDLE INITIAL, LAST)

8.DAYTIME TELEPHONE NUMBER (INCLUDE AREA CODE) ( ) —

9. SUBSCRIBER'S ADDRESS (STREET, CITY, STATE, ZIP CODE) CHECK IF NEW ADDRESS ❑

10. IS PATIENT COVERED UNDER OTHER HEALTH INSURANCE? NO ❑ YES ❑ IF YES, NAME OF OTHER INSURANCE COMPANY

NAME OF POLICY HOLDER

POLICY OR IDENTIFICATION NUMBER

IS PATIENT COVERED UNDER MEDICARE? NO ❑ YES ❑

IF THE SUBSCRIBER IS MARRIED, IS THE SPOUSE EMPLOYED? NO ❑ YES ❑
IF YES, GIVE THE NAME OF THE SPOUSE'S EMPLOYER

IF YES, PART A ❑ PART B ❑ MEDICARE HIC NUMBER

IS PATIENT ACTIVELY EMPLOYED? NO ❑ YES ❑ IF YES, NAME OF EMPLOYER

11. WAS PATIENT'S CONDITION DUE TO: AUTO ACCIDENT? NO ❑ YES ❑ ANY OTHER ACCIDENTAL INJURY? NO ❑ YES ❑ WORK RELATED ACCIDENT OR CONDITION? NO ❑ YES ❑

MEDICAL EMERGENCY? NO ❑ YES ❑

IF AN ACCIDENT, GIVE THE DATE OF THE ACCIDENT MO DAY YEAR ___/___/___

WAS ANOTHER PARTY AT FAULT? NO ❑ YES ❑

IF MEDICAL EMERGENCY GIVE DATE SYMPTOMS BEGAN MO DAY YEAR ___/___/___

IF YES, ATTACH A STATEMENT WITH DETAILS (SEE ACCIDENTAL INJURY ON THE REVERSE SIDE)

12.WAS PATIENT HOSPITALIZED? NO ❑ YES ❑

ADMISSION DATE MO DAY YEAR ___/___/___

IF YES, COMPLETE THE FOLLOWING:

DISCHARGE MO DAY YEAR ___/___/___

NAME OF HOSPITAL

NAME & ADDRESS OF ADMITTING PHYSICIAN

13.ARE BILLS FOR A CONSULTATION ATTACHED? NO ❑ YES ❑ IF YES, GIVE NAME OF PHYSICIAN WHO REQUESTED THE CONSULTATION

WAS THE CONSULTATION REQUESTED TO OBTAIN A SECOND SURGICAL OPINION? NO ❑ YES ❑

WAS SURGERY RECOMMENDED? NO ❑ YES ❑

14.ARE BILLS FOR MATERNITY ATTACHED? NO ❑ YES ❑ IF YES, WHAT IS THE DATE OF THE LAST MENSTRUAL PERIOD? MO DAY YEAR ___/___/___

15.STATE THE DIAGNOSIS, SYMPTOMS, ILLNESS OR INJURY FOR THE EXPENSES CLAIMED

HAS PATIENT HAD THESE SYMPTOMS/CONDITION BEFORE? NO ❑ YES ❑ IF YES, WHEN MO DAY YEAR ___/___/___

GIVE DATE SYMPTOM(S) FIRST STARTED MO DAY YEAR ___/___/___

GIVE DATE PHYSICIAN FIRST SEEN MO DAY YEAR ___/___/___

16.LIST BELOW ONLY THOSE CHARGES BEING CLAIMED AND ATTACH ORIGINAL ITEMIZED BILLS FROM THE PROVIDERS FOR THESE SERVICES

	NAME(S) OF PROVIDER(S)	*DESCRIPTION(S) OF SERVICE(S)*	*DIAGNOSIS (IF MORE THAN ONE)*	*FROM DATE* MO DAY YEAR	*TO DATE* MO DAY YEAR	*CHARGE*
A.				___/___/___	___/___/___	$.
B.				___/___/___	___/___/___	$.
C.				___/___/___	___/___/___	$.
D.				___/___/___	___/___/___	$.

17. TOTAL $.

18. THIS CLAIM FORM MUST BE SIGNED. IF NOT, IT WILL BE RETURNED.

I request benefits for these expenses and certify that the above information is correct and that the foregoing expenses were incurred for the above named patient. I authorize any physician, nurse, hospital or other providers or suppliers in possession of information concerning the patient to furnish such information to CareFirst BlueCross BlueShield upon request.

Subscriber Signature

Date MO DAY YEAR ___/___/___

Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

AUTHORIZATION FOR ASSIGNMENT OF BENEFITS (SEE REVERSE)

I, the undersigned, authorize CareFirst BlueCross BlueShield to make payment for benefits due herein to

Name of Provider

Provider's Tax or Social Security Number

Name of Provider

Provider's Tax or Social Security Number

Subscriber Signature

Date MO DAY YEAR ___/___/___

INSTRUCTIONS

THIS FORM IS TO BE USED TO SUBMIT A CLAIM FOR SERVICES UNDER YOUR HEALTH PLAN. TO AVOID HAVING YOUR CLAIM RETURNED:

- ✓ PREPARE A **SEPARATE CLAIM FORM** FOR EACH FAMILY MEMBER.
- ✓ COMPLETE **ALL OF THE INFORMATION REQUESTED** IN ITEMS 1 THRU 18.
- ✓ IF YOU **PREFER THAT BENEFITS BE PAID TO THE PROVIDER OF SERVICE BE SURE TO COMPLETE THE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS ON THE FRONT.** CAREFIRST BLUECROSS BLUESHIELD RESERVES THE RIGHT TO MAKE PAYMENT DIRECTLY TO THE SUBSCRIBER AND TO REFUSE TO HONOR THE ASSIGNMENT OF ANY CLAIM TO ANY PERSON OR PARTY.

EACH PROVIDER'S ORIGINAL ITEMIZED BILL MUST BE ATTACHED AND CONTAIN:

- ✓ THE LETTERHEAD INDICATING THE NAME AND ADDRESS OF THE PERSON OR ORGANIZATION PROVIDING THE SERVICE
- ✓ THE NAME OF THE PATIENT RECEIVING THE SERVICE
- ✓ THE DATE FOR EACH INDIVIDUAL SERVICE (A RANGE OF DATES CANNOT BE ACCEPTED)
- ✓ THE CHARGE FOR EACH INDIVIDUAL SERVICE
- ✓ A DESCRIPTION OF EACH SERVICE

ON EACH BILL, PLEASE CROSS OUT ANY CHARGES THAT WERE INCLUDED ON A PREVIOUS CLAIM. PERSONAL ITEMIZATIONS, CASH REGISTER RECEIPTS, CREDIT CARD RECEIPTS AND CANCELLED CHECKS ARE NOT ACCEPTABLE. ITEMIZED BILLS CANNOT BE RETURNED.

IN ADDITION TO THE ABOVE REQUIREMENTS, THE FOLLOWING INFORMATION WILL BE NEEDED:

ACCIDENTAL INJURY - STATEMENTS MUST CONTAIN DETAILS AS TO WHEN, WHERE AND THE MANNER IN WHICH THE INJURY OCCURRED, AS WELL AS THE NAME AND ADDRESS OF THE PARTY AT FAULT.

PRESCRIPTION DRUGS - BILLS MUST INCLUDE THE PRESCRIPTION NUMBER, THE NAME OF THE DRUG AND THE NAME OF THE PHYSICIAN PRESCRIBING THE MEDICATION.

PRIVATE DUTY NURSING - BILLS MUST INCLUDE THE SHIFT WORKED, THE CHARGE PER HOUR, THE NUMBER OF HOURS WORKED, THE NURSE'S PROFESSIONAL STATUS, PROFESSIONAL LICENSE NUMBER AND FAMILY RELATIONSHIP TO THE PATIENT, IF ANY. A STATEMENT FROM THE ATTENDING PHYSICIAN MUST ACCOMPANY THE CLAIM. THE STATEMENT SHOULD EXPLAIN THE MEDICAL NECESSITY OF THE SERVICE AND THE AUTHORIZATION FOR IT.

PROSTHETIC APPLIANCES AND THE RENTAL OR PURCHASE OF DURABLE MEDICAL EQUIPMENT - A STATEMENT FROM THE ATTENDING PHYSICIAN MUST ACCOMPANY THE CLAIM. THE STATEMENT SHOULD EXPLAIN THE MEDICAL NECESSITY OF THE EQUIPMENT AND THE PHYSICIAN'S AUTHORIZATION FOR IT.

PSYCHOTHERAPY - BILLS MUST INCLUDE THE LENGTH OF THE SESSION, THE TYPE OF SESSION AND THE PROVIDER'S PROFESSIONAL STATUS. IF THE PROVIDER IS OTHER THAN A MEDICAL DOCTOR, THE PROVIDER'S PROFESSIONAL LICENSE NUMBER MUST ALSO BE GIVEN.

FOR PATIENTS COVERED BY ANOTHER INSURANCE CARRIER OR MEDICARE - IF THE PATIENT IS CLAIMING BENEFITS FOR ANY CHARGES THAT ARE ELIGIBLE FOR BENEFITS UNDER ANY OTHER HEALTH INSURANCE POLICY OR MEDICARE PART A AND/OR PART B, THE EXPLANATION OF BENEFITS FORM FURNISHED BY THE OTHER CARRIER PERTAINING TO THESE CHARGES MUST BE INCLUDED WITH THE ITEMIZED BILLS. A CLEAR PHOTOCOPY OF THE OTHER CARRIER'S EXPLANATION OF BENEFITS FORM IS ACCEPTABLE IN PLACE OF THE ORIGINAL DOCUMENT.

FOR SERVICE RECEIVED OUTSIDE THE CAREFIRST BLUECROSS BLUESHIELD SERVICE AREA (MARYLAND, WASHINGTON DC AND NORTHERN VIRGINIA) THE CLAIM FORM AND ALL RELATED MATERIALS SHOULD BE SUBMITTED TO YOUR LOCAL BLUE CROSS AND BLUE SHIELD PLAN.

PLEASE REFER TO THE FOLLOWING PAGES FOR A LISTING OF THE LOCAL BLUES PLANS IN YOUR AREA.

BEFORE SUBMITTING YOUR CLAIM, PLEASE BE SURE THAT:

1. THE CLAIM FORM IS FULLY COMPLETED AND SIGNED.
2. THE ITEMIZED BILLS ARE ATTACHED.
3. YOU HAVE KEPT COPIES OF EACH DOCUMENT AND BILL FOR YOUR PERSONAL RECORDS

CareFirst BlueCross BlueShield
10455 Mill Run Circle
Owings Mills, MD 21117

When submitting claims for service from a non-participating provider received outside of the CareFirst BlueCross BlueShield service area (Maryland, Washington DC and northern Virginia) you must send your completed claim form to your local Blue Cross and Blue Shield plan. You must include your 3 digit prefix and your member ID number when submitting your claim.

For the appropriate address of your local plan, please refer to the directory below.

ALABAMA
Blue Cross and Blue Shield of Alabama
Attn: Jim Deane
450 Riverchase Parkway East
Brimingham, AL 35244

ALASKA
Premera Blue Cross
P.O. Box 91080
Seattle, WA 98111

ARIZONA
Blue Cross and Blue Shield of Arizona
P.O. Box 2924
Phoenix, Arizona 85062-2924

ARKANSAS
Arkansas Blue Cross and Blue Shield
P.O. Box 2181
Little Rock, AR 72203

CALIFORNIA
Blue Cross of California
P.O. Box 60007
Los Angeles, CA 90060-0007

CALIFORNIA
Blue Shield of California
P.O. Box 1505
Red Bluff, CA 96080-1505

COLORADO
Anthem Blue Cross and Blue Shield
P.O. Box 5747
Denver, CO 80217-5747

CONNECTICUT
Anthem Blue Cross and Blue Shield
P.O. Box 533
North Haven, CT 06473-0533

DELAWARE
Blue Cross Blue Shield of Delaware
P.O. Box 8831
Wilmington, DE 19899-8831

DISTRICT OF COLUMBIA
CareFirst BlueCross BlueShield
Mail Administrator
P.O. Box 14116
Lexington, KY 40512-4116

FLORIDA
Blue Cross and Blue Shield of Florida
Attn: Deb Rosendale
4800 Deerwood Campus Parkway
Dcc 200 3rd floor
Jacksonville FL, 32246

GEORGIA
Blue Cross and Blue Shield of Georgia
P.O. Box 9907
Cols, GA 31904

HAWAII
Blue Cross and Blue Shield of Hawaii
HMSA--BlueCard Department
Attn: Misrouted Claims
P.O. Box 2970
Honolulu, HI 96802

IDAHO
Blue Cross of Idaho Health Service
Attn: ITS BlueCard Department
3000 E. Pine Ave
Meridian, ID 83642

IDAHO
Regence BlueShield of Idaho
P.O. Box 31603
Salt Lake City, UT 84131-0603

ILLINOIS
Blue Cross and Blue Shield of Illinois
P.O. Box 805107
Chicago, IL 60680-4112

INDIANA
Anthem Blue Cross and Blue Shield Indiana
Anthem Document Management
P.O.Box 31780
Louisville, KY 40233

IOWA
Wellmark Blue Cross and Blue Shield
636 Grand Avenue, Station 39
Des Moines, Iowa 50309

JAMAICA
Blue Cross of Jamaica
The BlueCard Unit
Claims Department
85 Hope Road, Kingston 6
Jamaica, West Indies

KANSAS
Blue Cross and Blue Shield of Kansas
1133 SW Topeka Boulevard
P.O. Box 239
Topeka, KS 66629-0001

KENTUCKY
Anthem Blue Cross and Blue Shield
Anthem Document Management
P.O.Box 31780
Louisville, KY 40233

LOUISIANA
Blue Cross and Blue Shield of Louisiana
P.O. Box 98029
Baton Rouge, LA 70898-9029

MAINE
Anthem Blue Cross and Blue Shield
Anthem Blue Cross and Blue Shield
P.O. Box 533
North Haven, CT 06473

MARYLAND
CareFirst BlueCross BlueShield
Mail Administrator
P.O. Box 14116
Lexington, KY 40512-4116

MASSACHUSETTS
Blue Cross and Blue Shield of MA
Attn:BlueCard Claims Department
P.O. Box 986025
Boston, MA 02298

MINNESOTA
Blue Cross and Blue Shield of Minnesota
Route S201
P.O. Box 64560
St. Paul, MN 55164-0560

MISSISSIPPI
Blue Cross and Blue Shield of Mississippi
P.O. Box 1043
Jackson, MS 39215-1043

MISSOURI
Blue Cross and Blue Shield of Kansas City
Attn: NASCO Unit
P.O. Box 419016
Kansas City, MO 64141-6016

MISSOURI
Blue Cross and Blue Shield of Missouri
1831 Chestnut Street
St. Louis, MO 63103

MONTANA
Blue Cross and Blue Shield of Montana
P.O. Box 5004
Great Falls, MT 59405

NEBRASKA
Blue Cross and Blue Shield of Nebraska
7261 Mercy Road
Omaha, NE 68180-0001

NEVADA
Anthem Blue Cross and Blue Shield
P.O. Box 5747
Denver, CO 80217-5747

NEW HAMPSHIRE
Anthem Blue Cross and Blue Shield
3000 Goffs Falls Road
Manchester, NH 03111-00001

NEW JERSEY
Horizon Blue Cross and Blue Shield
BlueCard Claims
P.O. Box 1301
Neptune, NJ 07754-1301

NEW MEXICO
New Mexico Blue Cross and Blue Shield
Blue Cross Blue Shield of New Mexico
P. O. Box 27630
Albuquerque, New Mexico 87125

NEW YORK
BlueCross and BlueShield of Central NY
Excellus BCBS
344 South Warren St
P.O. Box 4979
Syracuse, NY 13221

NEW YORK
BlueCross BlueShield of the Rochester Area
Excellus BCBS
Attn: Claims
165 Court St
Rochester, NY 14647

NEW YORK
Blue Cross and Blue Shield of Utica- Watertown
Excellus BCBS-Utica Division
Attn: Claims receivable Unit
12 Rhoads Dr.
Utica, NY 13502

NEW YORK
Empire Blue Cross and Blue Shield
BlueCard Program
P.O. Box 3877
Church Street Station
New York, NY 10008-3877

NEW YORK
Blue Cross and Blue Shield of Western NY
BlueCross BlueShield of Western New York
P.O. Box 80
Buffalo, New York 14240-0080

NEW YORK
Blue Shield of Northeastern New York
P.O. Box 80
Buffalo, New York 14240-0080

NORTH CAROLINA
Blue Cross and Blue Shield of North Carolina
Attn: BlueCard
P.O. Box 35
Durham, NC 27702

NORTH DAKOTA
BlueCross BlueShield North Dakota
4510 13th Ave S
Fargo, ND 58121-0001

OHIO
Anthem Blue Cross and Blue Shield
Anthem Document Management
P.O. Box 31780
Louisville, KY 40233

OKLAHOMA
Blue Cross and Blue Shield of Oklahoma
BCBS of Oklahoma
Attn: Document Control
P.O. Box 3283
Tulsa, OK 74102-3283

OREGON
Regence BlueCross BlueShield of Oregon
P.O. Box 30805
Salt Lake City, UT 84130-0805

PENNSYLVANIA
Blue Cross of Northeastern Pennsylvania
Attn: Michelle Holzman, Supervisor ITS Claims
19 North Main St.
Wilkes-Barre, PA 17801

PENNSYLVANIA
Capital Blue Cross
P.O. Box 779503
Harrisburg, PA 17177-9503

PENNSYLVANIA
Highmark Blue Cross and Blue Shield
Attn: Document Preparation, Claims Scanning
P.O. Box 890062
Camp Hill, PA 17089-0062

PENNSYLVANIA
Independence Blue Cross
1901 Market St.
Attn: Host ITS Area C3
Philadelphia, PA 19103

PUERTO RICO
La Cruz Azul de Puerto Rico
BlueCard Department
P.O. Box 366068
San Juan, PR 00936-6068

RHODE ISLAND
Blue Cross and Blue Shield of Rhode Island
444 Westminster St
Providence, RI 02903
Attn: Mail Support Services

SOUTH CAROLINA
Blue Cross and Blue Shield of South Carolina
P.O. Box 100300
Columbia, SC 29202

SOUTH DAKOTA
Wellmark Blue Cross and Blue Shield
636 Grand Avenue, Station 39
Des Moines, Iowa 50309

TENNESSEE
Blue Cross and Blue Shield of Tennessee
BlueCross BlueShield of Tennessee
P.O. Box 180150
Chattanooga, TN 37402

TEXAS
Blue Cross and Blue Shield of Texas
Blue Cross Blue Shield of Texas
P.O. Box 660044
Dallas, Texas 75266-0044

U.S. VIRGIN ISLANDS
Blue Cross and Blue Shield of the U.S. Virgin Islands
P.O. Box 8470
St Thomas, VI 00801

UTAH
Regence BlueCross BlueShield
P.O. Box 30270
Salt Lake City, UT 84130-0270

VERMONT
Blue Cross and Blue Shield of Vermont
Attn: BlueCard Department
P.O. Box 186
Montpelier VT 05601-0186

VIRGINIA
Anthem Blue Cross and Blue Shield
P.O. Box 27401
Richmond, VA 23279

WASHINGTON
Premera Blue Cross
P.O. Box 91080
Seattle, WA 98111

WASHINGTON
Regence BlueShield
P.O. Box 21267
Seattle, WA 98111

WEST VIRGINIA
Mountain State Blue Cross and Blue Shield
BlueCard Unit
Attn: Pam Uchanski
45 20th Street
Wheeling, WV 26003

WISCONSIN
Blue Cross Blue Shield of Wisconsin
P.O. Box 2270
Fond du Lac, WI 54936-2270

WYOMING
Blue Cross and Blue Shield of Wyoming
Attn: Sherry Fierro
P.O. Box 2266
Cheyenne, WY 82003