Health Insurance Claim
Illinois Comprehensive Health Insurance Plan

BlueCross and BlueShield of Illinois

Filing Claims

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

1 MOST HOSPITALS AND DOCTORS WILL FILE A CLAIM DIRECTLY WITH US.

Please show your ICHIP, Blue Cross and Blue Shield identification card to the hospital or doctor.

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 ICHIP/Blue Cross and Blue Shield FIRST). After you receive an "EXPLANATION OF BENEFITS" form from Medicare showing what was paid, send a copy of that form 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 occurred give the date it happened, where it happened, and a brief description of the injury.
- Description of service received.
- Date of each treatment or surgical procedure.
- Charge for each treatment or surgical procedure.

If you would like to submit a claim for prescription drug benefits, and the prescription drug is <u>not</u> available through Blue Script, please submit the following information on the pharmacy bill:

- 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.

The Bill For The Following Services Should Show:

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 nurse's progress notes, must be attached to the nurse's bill.

ILLINOIS COMPREHENSIVE HEALTH INSURANCE PLAN CLAIM FORM

Send Completed Claim Form To:
Illinois Comprehensive Health Insurance Plan
Blue Cross and Blue Shield of Illinois
P.O. Box 805107
Chicago, Illinois 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

3

ID NUMBER -- Copy this from your ICHIP 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	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 -- indicate how payment is to be made.

☐ MAKE PAYMENT TO PROVIDER (hospital, doctor etc.) ☐ MAKE PAYMENT TO MEMBER, 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	WAS IT WORK RELATED? ☐ Yes ☐ No	DATE OF ACCIDENT:	WHERE DID IT HAPPEN? ☐ Work ☐ Home ☐ Other

BRIEFLY DESCRIBE INJURY:

COMPLETE 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.)	NUMBER OF BILLS SUBMITTED:

SPOUSE INFORMATION

SPOUSE'S NAME:	SOCIAL SECURITY NUMBER: ___ ___ ___/ ___ ___/ ___ ___ ___ ___	DATE OF BIRTH Month / Day / Year

IS YOUR SPOUSE EMPLOYED? ☐ Yes ☐ No -- If Yes, provide below:

EMPLOYER NAME:	PHONE NUMBER: ( )
ADDRESS:	

DOES YOUR SPOUSE HAVE OTHER INSURANCE? ☐ Yes ☐ No -- If Yes, provide below:

INSURANCE CARRIER NAME:	POLICY NUMBER:	EFFECTIVE DATE:
ADDRESS:		PHONE NUMBER: ( )

OTHER INSURANCE INFORMATION

ARE THERE ANY OTHER HEALTH CARE BENEFITS AVAILABLE to you, your spouse or dependents from: Employer or Group Insurance, Medicare, The Department of Public Aid; Medical Assistance No Grant Program (MANG), Aid to Medically Indigent (Article VII), The Division of Specialized Care for Children (DSCC), CHAMPUS etc.?
☐ Yes ☐ No -- If Yes, provide below:

POLICY HOLDER NAME:	POLICY HOLDER IS: ☐ Member ☐ Dependent	
INSURANCE CARRIER NAME:	POLICY NUMBER:	EFFECTIVE DATE:
ADDRESS:		PHONE NUMBER: ( )

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 photocopy 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. I accept full responsibility for the claim being submitted. Fraudulent statements or misrepresentation can cause loss of Plan coverage under the Medical Plan.

Sign Here _____ **Date** _____

Signature of Member