# HEALTH BENEFITS CLAIM FORM

CareFirst BlueChoice

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***

| 1. ID# / SOCIAL SECURITY # | 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<br>/ / | FEMALE ❑ MALE ❑ | *EE SP CH*<br>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 BlueChoice, Inc. 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 BlueChoice, Inc. 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 RENDERED UNDER YOUR CAREFIRST BLUECHOICE, INC. HEALTH PLAN. THE BLUECHOICE PROVIDER IS RESPONSIBLE FOR SUBMITTING CLAIMS FOR IN-NETWORK SERVICES. 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 BLUECHOICE, INC. 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.

**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

**THE CLAIM FORM AND ALL RELATED MATERIALS SHOULD BE SUBMITTED TO:**

CAREFIRST BLUECHOICE, INC.
MAIL ADMINISTRATOR
P.O. BOX 14116
LEXINGTON, KY 40512-4116