



Capital BlueCross

An Independent Licensee of the Blue Cross and Blue Shield Association

www.capbluecross.com

Medical Expense Claim Form for *Traditional, Comprehensive, *PPO, SeniorSM, SecuritySM, and Keystone Health Plan[®] Central HMO*

***Applies to all PPO products**

Dear Member:

We will make every effort to process your claim promptly and accurately. However, we need your assistance to ensure that the information you send us is complete. Please read the following instructions and complete the claim form which is attached. A description of the expenses which are covered by your program is contained in your certificate of coverage.

INSTRUCTIONS

- 1.** Please separate all receipts for each family member. A separate claim form is needed for each person.
- 2.** Receipts must include:
 - NAME AND ADDRESS (on letterhead stationery) of person, facility, or other provider of service or supply (hospital, doctor, medical center, etc.)
 - WHERE services were provided
 - Patient's full NAME
 - TYPE OF SERVICE or supply (doctor's office visit, nursing services, etc.)
 - A DESCRIPTION OR PROCEDURE CODE for each service
 - DATE each service or supply was provided
 - DIAGNOSIS, ILLNESS, OR INJURY for each service
 - AMOUNT CHARGED for each service or supply
 - NUMBER OF UNITS

SEE REVERSE SIDE OF
CLAIM FORM FOR EXAMPLES
OF ACCEPTABLE RECEIPTS
AND REQUIRED INFORMATION

Additional information—Claims for certain services may require you or the provider to submit additional information, such as:

- Ambulance: The point of origin and destination of ambulance (from home to hospital, etc.)
- Anesthesia: Length of time patient was under anesthesia and specific type of surgery for which anesthesia was given
- Blood: Number of pints received, charge for each pint, and the number of pints replaced by donor(s)
- Private Duty Nursing: Certification from doctor concerning medical necessity for the services; location of services (hospital, home, etc.); the hours or shifts worked; nurse's name and professional status (R.N., L.P.N., etc.); and the nurse's registration or license number
- Medical Documentation: May include physician notes and treatment plans

The following are **not** acceptable: cash register receipts, cancelled checks, money order receipts, personal lists or statements of payment on account. Since we keep all information you send us, you may want to make copies for your records.

- 3.** When sending receipts, please circle only the services or supplies you are claiming. If you have already received payment or rejection notices related to these services from a primary insurance carrier, please attach them to the corresponding receipts to expedite processing. These notices are usually called "Explanation of Benefits," or "Summary of Benefits."
- 4.** Preauthorization may be required for inpatient admissions and other selected procedures, including Home Medical Equipment, mental health, and substance abuse. Other services may require the submission of a treatment plan after a specified number of visits. For more information about the preauthorization process and program requirements, please refer to your certificate of coverage or call our Customer Service Department.
- 5.** Please detach at perforation and mail the claim form to:

Capital BlueCross
P.O. Box 779503
Harrisburg, PA 17177-9503

- 6.** If you have any questions about this claim form, please write to the address above or call 1-800-962-2242.

PLEASE READ

The numbered areas on this page explain more fully the corresponding questions on the claim form. It is important to print clearly on the claim form.

1. Patient/Member Information: Complete this section using the information on the patient's/member's identification card.

2. Subscriber Information: This section should be completed even if the patient and the subscriber are the same. The term 'subscriber' means the person whose employment or other status, except for family dependency, is the basis for coverage eligibility.

This section refers to the conditions or ailments that require the services to be obtained.

3. Acceptable			Not Acceptable	
A. Diabetes	John Doe, M.D.	01/01/2002	A. Laboratory Test	01/02/2002
B. Asthma	John Smith, D.O.	03/25/2002	B. See Attached	-----

4. If other members of the family were involved in this accident, write their names on the back of the claim form. If Workers' Compensation rejected your claim, please send a copy of the rejection letter with this claim form. If this question does **not** apply, please check "No" on the top line.

5. MEDICARE: This question should be answered regardless of age. Check "Yes" or "No." If yes, give effective date of enrollment (from Medicare ID Card). Please send itemized receipts along with the Explanation of Benefits Summary from Medicare.

6. If the patient has other coverage, check "Yes" and provide the information requested. Please send itemized receipts along with payment or rejection notices from the other insurance company. If other coverage does not apply, please check "No."

7. Please be sure to sign the claim form and attach copies of your itemized receipt or billing statement.



CLAIM FORM

please print in BLUE or BLACK ink

1.	PATIENT/MEMBER NAME	ID NUMBER	GROUP NUMBER
	DATE OF BIRTH (MO, DAY, YR) <input style="width:100%;" type="text"/>	GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female	RELATIONSHIP TO SUBSCRIBER <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other
2.	SUBSCRIBER NAME	DATE OF BIRTH (MO, DAY, YR) <input style="width:100%;" type="text"/>	EMPLOYEE STATUS <input type="checkbox"/> Active <input type="checkbox"/> Retired <input type="checkbox"/> Disabled <input type="checkbox"/> Other
	PRESENT ADDRESS	CITY	STATE ZIP CODE
3.	DESCRIBE CONDITIONS FOR WHICH YOU ARE REQUESTING BENEFITS AT THIS TIME:		
	Type of Injury or Illness	Name & Degree of Doctor Treating Illness	Date First Treated
	A. _____	_____	<input style="width:100%;" type="text"/>
	B. _____	_____	<input style="width:100%;" type="text"/>
	<small>(Use other side if needed)</small>		
4.	WERE EXPENSES DUE TO AN ACCIDENTAL INJURY? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "YES," complete below.)		
	A. Date of accident (MO, DAY, YR) <input style="width:100%;" type="text"/>	Place/Type of Incident:	<input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> School <input type="checkbox"/> Auto <input type="checkbox"/> Motorcycle <input type="checkbox"/> Other _____
	B. Give a brief description of the incident _____ _____		
	C. Has a claim been, or will a claim be, filed under any Workers' Compensation act? <input type="checkbox"/> Yes <input type="checkbox"/> No If denied, include a copy of your denial letter. Are you appealing the denial? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	D. Has a claim been, or will a claim be, filed against the person responsible for the injury? <input type="checkbox"/> Yes <input type="checkbox"/> No		
5.	MEDICARE: Is the patient entitled to benefits under Medicare Hospital Insurance (Part A)? <input type="checkbox"/> Yes <input type="checkbox"/> No Effective Date: <input style="width:100%;" type="text"/>		
	Is patient entitled to benefits under Medicare Medical Insurance (Part B)? <input type="checkbox"/> Yes <input type="checkbox"/> No Effective Date: <input style="width:100%;" type="text"/>		
	Health insurance number from Medicare ID Card _____		
	Are you submitting expenses incurred for Medical Emergency treatment received in a foreign country? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	Description of Medical Emergency: _____		
6.	OTHER COVERAGE: Does patient have additional/other health insurance coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "Yes," complete below.)		
	a. Insured's Name _____		
	b. Employer's Name _____		
	c. Insurance Company's Name _____		
	d. Policy/Identification No. _____	Effective Date <input style="width:100%;" type="text"/>	Cancellation Date <input style="width:100%;" type="text"/>
	Employment Status of Insured: <input type="checkbox"/> Active <input type="checkbox"/> Retired <input type="checkbox"/> Disabled		
	Type of Coverage <input type="checkbox"/> Family <input type="checkbox"/> Single <input type="checkbox"/> Husband & Wife <input type="checkbox"/> Parent & Child <input type="checkbox"/> Parent & Children		
	Type of Health Insurance		
	<input type="checkbox"/> Hospital	<input type="checkbox"/> Medical/Surgical	<input type="checkbox"/> Major Medical <input type="checkbox"/> Comprehensive Major Medical
	<input type="checkbox"/> HMO	<input type="checkbox"/> Drug	<input type="checkbox"/> Dental <input type="checkbox"/> Vision
	<input type="checkbox"/> Point-of-Service (POS)	<input type="checkbox"/> Preferred Provider Organization (PPO)	<input type="checkbox"/> Other _____
7.	I verify that the information given above, in support of this claim, is true and correct. Any person, who knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and subjects such person to criminal and civil penalties.		
	Member Signature _____	Date _____	(Area Code) Home Phone _____ (Area Code) Work Phone _____

