

INSTRUCTIONS TO SUBMIT A MAJOR MEDICAL CLAIM

When you have enough charges to satisfy your deductible, you may file a Major Medical claim! You DO NOT have to wait until the end of the year. In fact, you will probably get faster service if you send charges quarterly throughout the year. Details about your deductible can be found in your benefit booklet.

When you complete the attached Major Medical Claim Form, please follow the instructions carefully.

Unless every question is answered, we will return the form to you for the information. YOUR PAYMENT WILL THEN BE DELAYED.

1. Separate all bills for each family member. A separate claim form is needed for each person on your contract.
2. Bills must include:
 - ✓ Name and address (on letterhead stationery) of person, store or other provider of service or supply (hospital, doctor, pharmacy, etc.).
 - ✓ Patient's full name.
 - ✓ Type of service or supply: Type of doctor's visit (brief, intermediate, extended, etc.), type of x-ray (leg, chest, etc.).
 - ✓ Date each service or supply was provided.
 - ✓ Doctor's diagnosis and/or patient's chief complaint for each service.
 - ✓ Amount charged for each service or supply. (See examples below.)

BILLS MISSING ANY OF THIS INFORMATION WILL BE RETURNED TO YOU

The following are **not** acceptable: cash register receipts, cancelled checks, money order receipts, personal lists. You must submit the original bills, receipts and forms. Please keep copies; bills cannot be returned.

3. BILLS FOR THE FOLLOWING SERVICES SHOULD HAVE THIS ADDITIONAL INFORMATION.

- Prescription Drugs: Prescription number, name of drug, name of prescribing doctor.
- Private Duty Nurse: A Private Duty Nursing Certification Form must be submitted with each claim. Please contact our Claim and Benefit Service Division to obtain these forms. Please refer to your benefit card for the phone number.
- Durable Medical Equipment: Durable medical equipment must be certified as medically necessary by your physician on a Durable Medical Equipment Certification Form. Please contact our Claim and Benefit Service Division to obtain these forms. Please refer to your benefit card for the phone number.
- Blood Charges: Include the number of pints received, charges for each, and the number of pints replaced by donors.
- When sending bills, please circle only the services or supplies you are claiming. **If you have received any payment or rejection notices from CareFirst BlueCross BlueShield, Medicare or other insurance, please send them to us. These notices are usually called "Summary or Explanation of Benefits" sheets.**

4. STOP!

PLEASE KEEP COPIES OF YOUR BILLS. SUBMITTED BILLS CANNOT BE RETURNED TO YOU.

EXAMPLES OF ACCEPTABLE BILLS TO BE SUBMITTED WITH THIS CLAIM FORM

	ACCEPTABLE	NOT ACCEPTABLE								
PHYSICIAN BILL	<p style="text-align: center;">John Doe, M.D. 456 Main Street Hometown, U.S.A.</p> <p style="text-align: right;">March 1, 1999</p> <p>To Richard Roe</p> <table border="0" style="width: 100%;"> <tr> <td>2/01/99 Extended Office Visit – Cold</td> <td style="text-align: right;">\$ 35.00</td> </tr> <tr> <td>2/10/99 Consultation – Diabetes</td> <td style="text-align: right;">\$ 50.00</td> </tr> <tr> <td>2/28/99 Brief Home Visit – Virus</td> <td style="text-align: right;">\$ 25.00</td> </tr> <tr> <td></td> <td style="text-align: right; border-top: 1px solid black;">\$ 110.00</td> </tr> </table>	2/01/99 Extended Office Visit – Cold	\$ 35.00	2/10/99 Consultation – Diabetes	\$ 50.00	2/28/99 Brief Home Visit – Virus	\$ 25.00		\$ 110.00	<p style="text-align: center;">Hometown, U.S.A.</p> <p style="text-align: right;">March 1, 1999</p> <p style="text-align: center;">John Doe, M.D.</p> <p>To Richard Roe</p> <p>Professional service rendered \$110.00</p>
2/01/99 Extended Office Visit – Cold	\$ 35.00									
2/10/99 Consultation – Diabetes	\$ 50.00									
2/28/99 Brief Home Visit – Virus	\$ 25.00									
	\$ 110.00									
PRIVATE DUTY NURSING BILL	<p style="text-align: center;">789 Main Street Hometown, U.S.A.</p> <p style="text-align: right;">May 4, 1999</p> <p>To Mrs. Robert Doe</p> <table border="0" style="width: 100%;"> <tr> <td>Monday 2/7/99 8 AM - 12 AM</td> <td style="text-align: right;">\$40.00</td> </tr> <tr> <td>Thursday 2/8/99 8 AM - 12 AM</td> <td style="text-align: right;">\$40.00</td> </tr> <tr> <td></td> <td style="text-align: right; border-top: 1px solid black;">\$80.00</td> </tr> </table> <p>Service Prescribed by John Roe, M.D. 2/4/99</p> <p style="text-align: right;">Emma Jones, RN Registration No. 27595</p>	Monday 2/7/99 8 AM - 12 AM	\$40.00	Thursday 2/8/99 8 AM - 12 AM	\$40.00		\$80.00	<p style="text-align: right;">May 4 19 99</p> <p>Received from Mrs. John Doe</p> <p style="text-align: center;">Eighty Dollars</p> <p>Paid in full</p> <p style="text-align: right;">\$ 80.00 Emma Jones</p>		
Monday 2/7/99 8 AM - 12 AM	\$40.00									
Thursday 2/8/99 8 AM - 12 AM	\$40.00									
	\$80.00									
PRESCRIPTION DRUG BILL	<p style="text-align: center;">Roe Pharmacy 100 Main Street Hometown, U.S.A.</p> <p>Drug Name March 2, 1999</p> <p>Myra Doe, RX 976-384 \$4.50</p> <p style="text-align: center;">Dr. John Smith</p>	<p style="text-align: center;">Receipt</p> <p>March 2, 1999 \$4.50</p> <p style="text-align: right;">Thank You Roe Pharmacy</p>								
LICENSED PHYSICAL THERAPIST	<p style="text-align: center;">John Jones, L.P.T. 123 Main Street Hometown, U.S.A.</p> <p style="text-align: right;">April 21, 1999</p> <p>Date of care: 3/10/99</p> <p>Physical therapy office visit for Mechanical Traction</p> <p>Diagnosis: Ruptured Disc</p> <p>Patient: Terry Snow \$18.00</p>	<p style="text-align: center;">John Jones, L.P.T. 123 Main Street Hometown, U.S.A.</p> <p style="text-align: right;">April 21, 1999</p> <p>Services rendered for physical therapy \$18.00</p>								

PLEASE READ:

The numbered items on this page thoroughly explain the matching questions on the facing page.



Read Section 1 of instructions and then complete Section 1 of the claim form etc. ... please print or type
All questions must be answered or the claim will be returned.

1. SUBSCRIBER AND PATIENT INFORMATION:

The subscriber is the name that is on your CareFirst BlueCross BlueShield Membership card.
Copy your membership number from your membership card.
Fill in your present address and telephone number.
Copy your group number (example: X050 or 0442) from your membership card and fill in the name of your employer.
Complete the patient information fully, even if the subscriber and patient are the same person.



2. MEDICAL INFORMATION:

This section refers to injuries, conditions, diseases, or ailments that required the service and supplies shown on the bills you are submitting with this claim form. Please list the illness(es) and the date on which it first occurred.

FOR EXAMPLE:

	<u>ACCEPTABLE</u>	<u>NOT ACCEPTABLE</u>
A. Diabetes	1/1/99	A. Laboratory test 1/1/99
B. Asthma	3/25/99	B. See Attached



3. ACCIDENTAL INJURY:

If this question does not apply to the attached bills, please check no. If yes, complete all questions.



4. WORK RELATED INJURY:

Check yes or no. DO NOT LEAVE BLANK.



5. MEDICARE:

These questions must be answered regardless of age. CHECK "YES" OR "NO". If yes, give effective date of Medicare entitlement (from Medicare Health Insurance card). Medicare is a federal health insurance program for people 65 or over and for certain disabled individuals.



6. OTHER HEALTH INSURANCE COVERAGE:

IF THE ANSWER IS YES, BE SURE TO COMPLETE ENTIRE SECTION. Please send itemized bills along with payment or rejection notices from the other insurance company. **This question must be answered or claim will be returned.**



7. AUTHORIZATION AND SIGNATURE:

Please read the authorization and sign the claim form. Forms without signatures will be returned.

When all the above items have been completed and checked, mail the claim form and itemized bills to:

Mail Administrator
P.O. Box 14115
Lexington, KY 40512-4115



TEAR OFF this sheet. Send us only the Major Medical claim form on opposite page and appropriate bills.

MAJOR MEDICAL CLAIM

1. Subscriber's Legal Name (Last, First, Middle Initial)		Patient's Legal Name (Last, First, Middle Initial)				
Membership Number		Patient's Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		Patient's Relationship to Subscriber <input type="checkbox"/> ¹ Self <input type="checkbox"/> ² Spouse <input type="checkbox"/> ³ Child		
Subscriber's Address (Street) <input type="checkbox"/> Check box if NEW address		Patient's Date of Birth	MO.	DAY	YR.	
City	State	Zip Code				
Telephone Number						
Group Number and Name						

IMPORTANT: ALL QUESTIONS MUST BE ANSWERED

2. List those illnesses for which you are submitting bills and date of first symptom.

_____	Date _____	_____	Date _____
_____	Date _____	_____	Date _____

3. Was the treatment the result of an accidental injury? Yes No

Description of Accident _____

Date of Accident _____ Where Accident Occurred _____

4. Was illness(es) or injury(ies) in any way work related? Yes No

5. Does patient have Medicare? Yes No

a. Medicare Part A (Hospital Insurance)? Yes No

b. Medicare Part B (Physician's Coverage)? Yes No

Effective Date of Coverage _____

Month / Day / Year

HEALTH INSURANCE CLAIM NUMBER _____

6. In addition to coverage under this program, is patient covered under any other insurance providing health care benefits or services?

Yes No If "YES", please complete:

a. Name of Policy Holder _____ Relationship to Patient _____

b. Name of Insuring Co. _____

c. Policy or Certificate No. _____ d. Effective Date of Coverage _____

Month / Day / Year

e. Check type of coverage: Hospital Surgical-Medical Major Medical Other (specify) _____

f. Check One: I have Family Husband and Wife Individual Parent and Child coverage with this carrier.

g. Name and Address of Policy Holder's Employer _____

7. I certify the above is complete and correct and that I am claiming benefits only for charges incurred by the patient named above. Authorization is hereby given to any hospital, physician, or other provider which participated in any way in my care and treatment to release to the CareFirst BlueCross BlueShield Plan any medical information which they in their judgment deem necessary to the adjudication of this claim.

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

X _____
SIGNATURE OF SUBSCRIBER DATE

