

Federal Employee Program

Health Benefits Claim Form

Please review the instructions on the reverse side of this form before completing.

1. PATIENT INFORMATION

A	ENROLLMENT CODE	IDENTIFICATION NUMBER
1	R	

B PATIENT'S NAME (First, Middle Initial and Last)	C PATIENT'S DATE OF BIRTH Month Day Year	D PATIENT'S SEX Male <input type="checkbox"/> Female <input type="checkbox"/>
E NAME OF ENROLLEE OR POLICY HOLDER (First, Middle Initial and Last)	F DATE OF BIRTH Month Day Year	G PATIENT'S RELATIONSHIP TO ENROLLEE Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/>

If the patient's last name is different from the enrollee's, please attach a statement explaining the relationship.

H ENROLLEE'S CURRENT ADDRESS (Street, City, State and Zip Code) **CHECK IF NEW ADDRESS**

PLEASE COMPLETE INFORMATION BELOW ONLY IF IT HAS CHANGED SINCE YOU LAST GAVE IT TO US. IF NO CHANGES, GO TO #5.

2. OTHER HEALTH INSURANCE Is the patient covered by additional health insurance through an employer, a group such as a professional organization, or any other group health insurance, including other Blue Cross and/or Blue Shield Coverage? Yes No
If yes, please complete this section.

A NAME AND ADDRESS OF INSURING COMPANY (Street, City, State and ZIP Code)	B EFFECTIVE DATE Month Day Year	TERMINATION DATE Month Day Year
C NAME OF POLICY HOLDER (First, Middle Initial and Last) AND HIS/HER EMPLOYER	D DATE OF BIRTH Month Day Year	E IDENTIFICATION NUMBER (Include all letters and numbers)

3. MEDICARE PLEASE COMPLETE THIS SECTION ON MEDICARE REGARDLESS OF THE PATIENT'S AGE
If you are covered by a Medicare HMO/Prepaid Plan, please leave Sections A and B Blank

A MEDICARE PART A (Hospital Insurance) If yes, effective date Month Day Year <input type="checkbox"/> Yes <input type="checkbox"/> No	B MEDICARE PART B (Medical Insurance) If yes, effective date Month Day Year <input type="checkbox"/> Yes <input type="checkbox"/> No	C MEDICARE HMO/ PREPAID PLAN If yes, effective date Month Day Year <input type="checkbox"/> Yes <input type="checkbox"/> No	D If the patient is eligible for Medicare due to End-Stage Renal Disease, please indicate the beginning date of renal treatment or transplant. Month Day Year
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4. EMPLOYMENT **A** Is the patient presently employed? Yes No If the patient is retired from the Federal Government, but still employed, please complete the following:

B NAME AND ADDRESS OF COMPANY OR GOVERNMENT AGENCY (Street, City, State and Zip Code)

5. DIAGNOSIS Describe illness, injury or symptoms requiring treatment. If illness, injury or symptoms are related to an accident, please complete A, B and C.

A DATE OF ACCIDENT Month Day Year	B TIME AM <input type="checkbox"/> PM <input type="checkbox"/>	C LOCATION At Home <input type="checkbox"/> Motor vehicle accident <input type="checkbox"/> Was the accident caused by someone else? At Work <input type="checkbox"/> If so, what state _____ <input type="checkbox"/> Yes <input type="checkbox"/> No Other _____ Other <input type="checkbox"/> Please explain _____
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6. CHARGES Please list below those charges that you are claiming for benefits. Use a separate line for each type of service or provider.

PLEASE ATTACH ITEMIZED BILLS

NAME OF PROVIDER MAKING CHARGE (Doctor, Hospital, etc. Two or more bills from the same provider may be entered on one line if they are for the same type of service.)	DESCRIPTION OF CHARGE (Office Visits, Therapy from Mental Conditions, etc.)	DATE OF SERVICE OR PURCHASE (If there is only one date, show it under "FROM".)		CHARGE
		FROM	TO	

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 provider of service, which participated in any way in my care, to release to the Blue Cross and/or Blue Shield Plan any medical information which they deem necessary to adjudicate this claim.

7. SIGNATURE

Signature of Enrollee or Patient	Date	Daytime telephone number including area code
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Failure to sign this claim form may delay processing.

INSTRUCTIONS

Please complete a separate claim form for each patient, and remember to file all claims by December 31 of the calendar year after the one in which the covered care or service was provided. Since most of the information requested on this form is self-explanatory, we did not include specific instructions for each item. However, please complete each item. If the information requested does not apply to the patient, indicate N/A (NOT APPLICABLE).

Special care should be taken when completing the following items:

1A and 2E These spaces are for the Blue Cross and Blue Shield Service Benefit Plan Enrollment Code and Identification Number (Item 1A) and other Health Insurance Identification Number (Item 2E). When completing these items, please ensure that these numbers and letters are exactly as they appear on your identification card(s). Also, please ensure that the patient's social security number is completed in 1A.

3A, B and C Medicare covers persons age 65 and over and persons who qualify because of disabling conditions such as End-Stage Renal Disease. **THEREFORE, PLEASE COMPLETE ITEMS 3A AND B REGARDLESS OF THE PATIENT'S AGE.** Item C should be completed if applicable.

ITEMIZED BILLS FOR COVERED SERVICES OR SUPPLIES MUST BE ATTACHED TO THIS FORM AND MUST INCLUDE THE FOLLOWING:

- Name and address of the provider of the service or supply.
- Date and type of service or supply.
- Diagnosis.
- Full name of the patient.
- Charge for each service or supply.

Personal itemizations, cash register receipts and cancelled checks are not acceptable. Since itemized bills cannot be returned, please be sure to make copies for your records. In addition, bills for home nursing care must show the professional status, such as R. N. (Registered Nurse). Bills for all drugs and medicines dispensed by a physician, the outpatient department of a hospital or any other non-retail-pharmacy provider must show the name of each drug or medicine.

Joseph Warowes
102 West 35th Street
Healthville, U.S.A.

Dayton Pendridge, M.D.
101 Fourth Street
Healthville, U.S.A.

SAMPLE

For Professional Services Rendered To:
Virginia E. Warowes

1/22/94 Examination
~~Chest X Ray~~
~~GGG~~
2/5/94 Office Visit

\$ XXX
~~XXX~~
XXX
XXX

PLEASE CROSS OUT THOSE CHARGES THAT WERE INCLUDED ON A PREVIOUS CLAIM

NAME OF THE PATIENT RECEIVING THE SERVICES OR SUPPLIES

DATE EACH SERVICE OR SUPPLY WAS PROVIDED

DESCRIPTION OF THE SERVICES OR SUPPLIES PROVIDED

NAME OF THE PERSON OR ORGANIZATION PROVIDING THE SERVICES OR SUPPLIES

CHARGE FOR EACH

RETAIL PHARMACY PROGRAM

Prescription drugs and supplies purchased on and after January 1, 1994, from a Preferred retail pharmacy in the U.S. or Puerto Rico will be filed for the member. Preferred pharmacies will not file claims for drugs requiring prior approval. Claims for drugs not filed by a retail pharmacy must be submitted to the Retail Pharmacy Program by the member on the Retail Prescription Drug Claim Form. Call 1-800-624-5060 for more information, claim forms and customer service assistance. The claim form provides detailed instructions for submission of the form and should be mailed to: Service Benefit Plan Retail Pharmacy Program, P.O. Box 52057, Phoenix, AZ 85072-2057.

SPECIAL SERVICES

Certain services such as physical, speech and occupational therapy, therapy for mental conditions, durable medical equipment, home nursing care and dental care resulting from an accidental injury may require additional information along with this claim form. Call your local Blue Cross and/or Blue Shield Plan before submitting your claim for such services; they will send you additional forms, if needed.

FOR PATIENTS COVERED BY MEDICARE

When the patient is covered by Medicare Part A (Hospital Insurance) and/or Medicare Part B (Medical Insurance) and incurs expenses which are covered by Medicare, if Medicare is primary (it pays first), your claim must be submitted to Medicare first (**See Note Below**). After the Medicare payment has been made, a claim for the expenses not paid by Medicare, to include a copy of your **Itemized bill**, can be submitted to your local Blue Cross and/or Blue Shield Plan, along with the appropriate forms from Medicare. For retail pharmacy prescription drug expenses, see the instructions above.

1. For Medicare Part A inpatient services, attach the "Explanation of Benefits" form from Medicare.
2. For Medicare Part B services, attach the "Explanation of Medicare Benefits" and/or the "Your Record of Part B Medicare Benefits Used" form furnished by the Medicare Carrier or Intermediary. Also, a copy of your itemized bill should be sent along with the Medicare Information.

NOTE: If the following conditions are met, the Blue Cross and Blue Shield Service Benefit Plan is primary (it pays first).

- If you are 65 or over and employed by the federal government and have Medicare Part A (or Parts A and B);
- If you or your spouse are employed by the federal government and your covered spouse is 65 or over and has Medicare Part A (or Parts A and B);
- If the patient (you or a covered family member) is under 65, eligible for Medicare benefits only because of End-Stage Renal Disease (ESRD) and is within the first 18 months of eligibility to receive Medicare Part A benefits; or
- If the patient (you or a covered family member) is under age 65 and eligible for Medicare solely on the basis of disability, and you are employed by the federal government.

FOR PATIENTS COVERED BY OTHER HEALTH INSURANCE

When submitting charges for services or supplies that have been partially paid by other group health insurance, **attach a copy of the Notice of Payment or Explanation of Payment from the other health care insurer.**

THIS COMPLETED FORM, TOGETHER WITH ITEMIZED BILLS AND SUPPORTING MATERIAL, SHOULD BE SUBMITTED TO YOUR LOCAL BLUE CROSS AND/OR BLUE SHIELD PLAN.