PATIENT CLAIM FORM

CLAIM CONTROL NUMBER ● FOR OFFICE USE ONLY

Blue Cross of California

An independent Licensee of the Blue Cross Association

PATIENT INFORMATION

NAME _____ (LAST / FIRST / MIDDLE)

DATE OF BIRTH (MO / DAY / YR)

SEX (M / F)

RELATIONSHIP TO MEMBER (SELF / SPOUSE / CHILD)

OCCUPATION

EMPLOYER

IS PATIENT COVERED BY MEDICARE? ❑ YES ❑ NO

IF "YES" MEDICARE I.D. NUMBER

EFFECTIVE DATES (HOSP) PART A (MO / DAY / YR) (MED) PART B (MO / DAY / YR)

PATIENT WAS TREATED FOR: ❑ INJURY ❑ ILLNESS ❑ PREGNANCY

DATE OF INJURY, ONSET OF ILLNESS OR PREGNANCY (MO / DAY / YR)

WAS CONDITION RELATED TO EMPLOYMENT? ❑ YES ❑ NO

DESCRIBE BRIEFLY PATIENT'S ILLNESS OR INJURY . . .
IF INJURY, HOW IT OCCURRED.

OTHER INSURANCE INFORMATION

DOES PATIENT HAVE OTHER HEALTH INSURANCE? ❑ YES ❑ NO

POLICY HOLDER NAME

INSURANCE COMPANY NAME AND ADDRESS

EFFECTIVE DATE (MO / DAY / YR)

POLICY NUMBER

MEMBER INFORMATION

I.D. NUMBER

GROUP NO.

DAYTIME PHONE NO. ( )

NAME _____ (LAST / FIRST / MIDDLE)

STREET ADDRESS

CITY STATE ZIP

NEW ADDRESS ❑ YES ❑ NO IF YES, HAVE EMPLOYEE SIGN THIS FORM.

MEMBER'S MARITAL STATUS IF OTHER COVERAGE EXISTS:
❑ SINGLE ❑ MARRIED ❑ LEGALLY SEPARATED ❑ DIVORCED ❑ WIDOWED

COMPLETE IF YOU ARE MARRIED:

NAME OF SPOUSE

DATE OF BIRTH (MO / DAY / YR)

SPOUSE'S SOCIAL SECURITY NUMBER

IS YOUR SPOUSE EMPLOYED? ❑ YES ❑ NO
IF YES, NAME AND LOCATION OF SPOUSE'S EMPLOYER:

EMPLOYER'S NAME AND ADDRESS

NAME OF SPOUSE'S GROUP HEALTH PLAN

IF DIVORCED OR LEGALLY SEPARATED, AND CLAIM IS FOR A DEPENDENT CHILD, PLEASE FURNISH THE FOLLOWING:

OTHER PARENT'S NAME _____ (LAST / FIRST / MIDDLE)

ADDRESS

EMPLOYER'S NAME AND ADDRESS

REFERRING PHYSICIAN

If the bill is from a Licenced Clinical Social Worker; Marriage, Family and Child Counselor; Audiologist; or Occupational, Physical, Respiratory or Speech Therapist, what is the name of the physician who ordered the service?

Dr. _____

PRESCRIPTION DRUGS - List only medications requiring a written prescription. All pharmacy receipts must be attached.

PURCHASE DATE Mo Day Yr	Rx NUMBER	DRUG NAME	DIAGNOSIS	COST
				$
				$
				$
				$
				$
			TOTAL	$

Please read both sides of this form carefully. Use a separate Patient Claim Form for EACH PATIENT. Please PRINT or TYPE.

YOUR COOPERATION IN COMPLETING ALL ITEMS ON THE CLAIM FORM AND ATTACHING ALL REQUIRED DOCUMENTATION WILL HELP EXPEDITE QUICK AND ACCURATE PROCESSING OF YOUR CLAIM.

❑ TOTAL NUMBER OF BILLS ATTACHED

I certify that the information on this claim form is true and correct to the best of my knowledge. I authorize the release of any medical information necessary to process this claim.

PATIENT'S SIGNATURE (PARENT'S SIGNATURE IF PATIENT IS MINOR) DATE

GS-5 11/95

ABOUT THIS FORM

Dear Member:

Usually, all providers of health care will bill us directly for services to you and your enrolled dependents.

This is the preferred procedure—you are not bothered with claim forms, and we often need more details than are ordinarily provided on bills to patients.

But sometimes a physician may not bill us. Or an ambulance company, for example, may send the bill directly to you. In either instance, we have no way of knowing about your claim.

That is why this form was developed. Use it to notify us of any covered health service for which we have not already been billed. You are urged to send us each bill immediately upon receipt.

Please read the instructions about how to use this form. It is for your convenience.

We are happy to serve you.

HOW TO USE THIS FORM

- Please complete a separate claim form for each patient.
- Attach original medical bills. We suggest that you keep copies for your records.
- If you are enrolled in Medicare, attach a clear copy of the Explanation of Benefits and the related itemized bill.
- If Blue Cross is not your prime carrier, please include an Explanation of Benefits from your other carrier.

WHEN TO USE THIS FORM

- Each time you submit bills, including those for prescription drugs, ambulance services and appliances not usually billed directly to Blue Cross.
- Do not use those form for bills which are being sent directly to Blue Cross by hospital, doctor, or laboratory.

BILLS MUST BE ITEMIZED

Cancelled check, cash register receipts and non-itemized "balance due" statements cannot be processed. Each itemized bill must include:

1. Name and address of provider (doctor, hospital, laboratory, or pharmacy, ambulance service, etc.)
2. Name of patient
3. Date of service
4. Amount charged for each service
5. Diagnosis or reason for treatment.

Write your Group Number and your Blue Cross ID Number on the face of each bill.

THE FOLLOWING INFORMATION MUST ALSO BE INCLUDED ON BILLS FOR THESE ITEMS:

PRESCRIPTION DRUGS:

- RX number and name of drug

REGISTERED AND LICENSED VOCATIONAL NURSES:

- Hours and dates of service
- Location of service (residence or name of hospital)
- Written documentation of physician's referral (must include the state license number, plan of treatment and estimated duration of treatments)

PROSTHETIC DEVICES, APPLIANCES OR DURABLE MEDICAL EQUIPMENT:

- Doctor's orders or prescriptions
- Purchase price

AMBULANCE

- Pick-up and delivery points
- Number of miles

WHERE TO SEND COMPLETED CLAIM FORMS

Mail completed form plus itemized bills to the appropriate address listed on your Blue Cross ID Card.

CLAIM INFORMATION

Claims or benefit questions will be answered by contacting the appropriate Blue Cross of California Customer Service office listed on your Blue Cross ID card.