HEALTH BENEFITS CLAIM FORM

CareFirst

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

*THIS FORM CAN ALSO BE USED FOR FILING CLAIMS FOR CAREFIRST BLUECHOICE OPT-OUT *PLUS*.

1. IDENTIFICATION NUMBER	2.GROUP NUMBER OR ENROLLMENT CODE	3.PATIENT'S NAME (FIRST, MIDDLE INITIAL, LAST)

4. PATIENT'S DATE OF BIRTH MO / DAY / YEAR ____ / ____ / ____

5. PATIENT'S SEX FEMALE ☐ MALE ☐

6. PATIENT'S RELATIONSHIP TO SUBSCRIBER: *EE* *SP* *CH*
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 ☐ **IF YES, COMPLETE THE FOLLOWING:**

ADMISSION DATE MO / DAY / YEAR ____ / ____ / ____ 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

GIVE DATE SYMPTOM(S) FIRST STARTED MO / DAY / YEAR ____ / ____ / ____

HAS PATIENT HAD THESE SYMPTOMS/CONDITION BEFORE? NO ☐ YES ☐ IF YES, WHEN 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*	*TO DATE*	*CHARGE*
A.			MO / DAY / YEAR	MO / DAY / YEAR	$.
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 BlueCross BlueShield upon request.

_____ MO / DAY / YEAR ____ / ____ / ____

Subscriber Signature ***Date***

Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or 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 BlueCross BlueShield 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

_____ MO / DAY / YEAR ____ / ____ / ____

Subscriber Signature ***Date***

INSTRUCTIONS

THIS FORM IS TO BE USED TO SUBMIT A CLAIM FOR SERVICES UNDER YOUR HEALTH PLAN. 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 BLUECROSS BLUESHIELD 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.

FOR SERVICE RECEIVED OUTSIDE THE CAREFIRST BLUECROSS BLUESHIELD SERVICE AREA (MARYLAND, WASHINGTON DC AND NORTHERN VIRGINIA) THE CLAIM FORM AND ALL RELATED MATERIALS SHOULD BE SUBMITTED TO YOUR LOCAL BLUE CROSS AND BLUE SHIELD PLAN.

PLEASE REFER TO THE FOLLOWING PAGES FOR A LISTING OF THE LOCAL BLUES PLANS IN YOUR AREA.

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

CareFirst BlueCross BlueShield
10455 Mill Run Circle
Owings Mills, MD 21117

Your provider should submit your claims to the local BlueCross BlueShield plan. You can locate that information by calling 1-800-810-BLUE and request your rendering provider's servicing Plan or locate it via www.bcbs.com and by entering your provider's zip code. The affiliated Plan link will display to locate the claims mailing address for the Plan.

or

You can mail your claim to the following address:

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

If you mail to the Kentucky address above, it could take up to 30 days to process your claim.