



**Independence
Blue Cross
Pennsylvania
Blue Shield**

INSTRUCTIONS

On How to Submit A Major Medical Claim

Please read carefully before completing the attached claim form.

- **TO AVOID DELAYS AT THE END OF THE YEAR, PLEASE FILE YOUR CLAIMS THROUGHOUT THE YEAR AS YOUR EXPENSES ARE INCURRED.**
- Please attach legible, itemized bills for all expenses being claimed, to this Major Medical claim form. **SEPARATE** itemized bills must be submitted together with a **SEPARATE** claim form for **EACH PATIENT**.

PLEASE NOTE: Cash register receipts, cancelled checks, money order receipts and personal itemizations are **NOT ACCEPTABLE** as itemized bills.

Please Be Sure All Bills Being Submitted Contain The Following:

- Name, status, (professional title, e.g., M.D., D.O. etc.) and address on the official billhead of the Provider rendering the service or supplying the item
- Patient's full name
- Type of service rendered or item supplied (e.g. doctor's office visit, prescription drugs, nurses services, etc.)
- The date and amount charged for EACH service rendered or item supplied. (See examples of acceptable bills on back of claim form.)

BILLS FOR THE FOLLOWING SERVICES MUST HAVE THE FOLLOWING ADDITIONAL INFORMATION:

- **Prescription Drugs:**
The prescription number and/or name must be submitted. If the purchase is a refill, the refill date must be indicated on the bill.
- **Durable Medical Equipment/Supplies (wheelchairs, braces, oxygen, etc.):**
A doctor's certification* **MUST** be submitted. If renting, have the supplier note the purchase price of the equipment and the length of time the item will be medically needed.
- **Private Duty Nursing:**
A doctor's certification* **MUST** be submitted. Also, the nurse's status (R.N., or L.P.N.), registration or license number and the hours worked must be provided. Please do not submit bills for the expenses of unlicensed nurses and nurses aides.
- **Blood:**
Bills must include: number of pints received, charges for each and the number of pints actually replaced by donors. Paid receipts must be submitted with each bill.

*The physicians' authorization for the specific treatment.

BILLS MUST BE SUBMITTED NO LATER THAN THE END OF THE CALENDAR YEAR FOLLOWING THE YEAR THE SERVICE WAS INCURRED.

- **IMPORTANT!**
- When submitting an itemized bill, please cross off all services or supplies you are not claiming.
- **IF YOU'VE RECEIVED ANY PAYMENT OR REJECTION NOTICES (USUALLY CALLED "SUMMARIES" OR "EXPLANATION OF BENEFITS") FROM BLUE CROSS, BLUE SHIELD, MEDICARE OR 65-SPECIAL, PLEASE SEND US COPIES.**
- **DOUBLE CHECK!**
Please be sure you have included all the necessary information, so that we can process your Major Medical claim promptly. Unless every question is answered, the claim may be returned to you, and any appropriate payments directly to you will be delayed.
- Since we must keep the bills, receipts, and claim form for our records, we suggest you make photocopies for your own records.
- Send your claims to Independence Blue Cross, P.O. Box 13497, Phila., PA 19101-3497





Independence
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Major Medical Claim Form

Independence Blue Cross, P.O. Box 13497, Philadelphia, PA 19101-3497

1 I certify that the information provided on this claim form is correct and complete, and that I am claiming benefits only for charges actually incurred by the patient named. I authorize any hospital, physician or other provider who participated in the care and treatment of the patient to release to the Blue Cross and Blue Shield Plans all medical or other information requested for the adjudication of this claim. I hereby agree to reimburse the Blue Cross and Blue Shield Plans in full should this claim be incorrectly paid.

APPLICANT SUBSCRIBER'S SIGNATURE _____ DATE _____ (Area Code) HOME PHONE _____ (Area Code) WORK PHONE _____
(If we may contact you at work)

APPLICANT SUBSCRIBER'S NAME (POLICY HOLDER) _____ IDENTIFICATION NO. ON I.D. CARD _____ GROUP NO. AND LETTER ON I.D. CARD _____

PRESENT ADDRESS—STREET _____ CITY _____ STATE _____ ZIP CODE _____

IF THIS IS A NEW ADDRESS, DO YOU AUTHORIZE US TO CHANGE YOUR PERMANENT RECORD? YES NO

ONLY COMPLETE IF YOUR BLUE SHIELD MEDICAL/SURGICAL CONTRACT IS: PLAN C PLAN 1800S PLAN 5000S
PLEASE CHECK ONE OF THE FOLLOWING STATEMENTS: MY CONTRACT IS: SINGLE/NO DEPENDENT FAMILY
INCOME FOR THE CALENDAR YEAR PRECEDING DATES OF SERVICE WAS:
 UNDER \$6,000 \$6,000-\$11,999 \$12,000-\$17,999 \$18,000-\$23,999 \$24,000-\$35,999 \$36,000 AND OVER

2 PATIENT'S FULL NAME (No Nicknames Please) _____ PATIENT'S DATE OF BIRTH _____ SEX _____
Month / Day / Year Male Female
RELATIONSHIP OF PATIENT TO APPLICANT SUBSCRIBER
 Self Spouse Male Child
 Female Child Other _____
SUBSCRIBER EMPLOYMENT STATUS
ACTIVE RETIRED DISABLED

3

PRIMARY DIAGNOSIS	DOCTOR NAME	SECONDARY DIAGNOSIS	DOCTOR NAME
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

4 WERE EXPENSES DUE TO AN INJURY? NO YES If yes,
A. Give date of injury _____ / _____ / _____ Give type/place of injury Work Home Auto Motorcycle Other _____
Month Day Year
B. Give brief description of injury _____
C. Has claim been or will claim be filed under any Worker's Compensation Act? NO YES
D. If you were injured, have you contacted a lawyer? NO YES
If yes, give your Attorney's name and address _____

5 **Medicare** is the patient entitled to benefits under Medicare Hospital Insurance (Part A)?
 No Yes Effective Date _____ / _____ / _____
Month Day Year
Is the patient entitled to benefits under Medicare Medical Insurance (Part B)?
 No Yes Effective date _____ / _____ / _____
Month Day Year
Enter your Health Insurance number from the Medicare I.D. card _____
Prior Blue Cross Identification Number (If Any): _____

6 **Other/Coverage?** IS THE PATIENT COVERED UNDER ANY OTHER HEALTH INSURANCE POLICY? YES NO
IF YES, COMPLETE THE FOLLOWING: a. WHAT IS THE EFFECTIVE DATE OF COVERAGE? _____
b. Insured's Name _____ c. Insured's Date of Birth _____
d. Insured's Employer Name _____ Employer's Phone Number _____
e. Policy or Identification Number _____
f. Applicant Subscriber's Social Security Number _____ Spouse's Social Security Number _____
g. Name and Address of Insurance Company _____
h. Type of Coverage Hospital Physician Major Medical Vision Prescription Dental Other _____

A SEPARATE CLAIM FORM MUST BE SUBMITTED FOR EACH PATIENT. COMPLETE ALL ITEMS, THEN SIGN AND DATE THIS FORM. PLEASE DO NOT FORGET TO ENCLOSE ALL DOCTOR BILL RECEIPTS AND MEDICARE STATEMENTS.

IF NOT SIGNED—THIS CLAIM WILL BE RETURNED

EXAMPLES

Of Itemized Bills

PHYSICIAN BILLS

Doctor's name and address → John Smith, M.D.
606 Center Street
Hometown, PA 15289

Full name of patient (Separate bill should be submitted for each member of family for whom benefits are being claimed.) → John Jones

FOR PROFESSIONAL SERVICES TO:

Date of Treatment	Charge	Name of Condition and Service
1/10/86	\$40.00	401.9 Hypertension 90040 Brief Office Visit
1/17/86	\$60.00	487.1 Influenza 90050 Intermediate Office Visit
2/12/86	\$40.00	727.3 Bursitis 90040 Brief Office Visit
3/22/86	\$25.00	12002 Suture of laceration (left hand)

Date of each treatment → 1/10/86, 1/17/86, 2/12/86, 3/22/86

Treatments shown separately → 1/10/86, 1/17/86, 2/12/86, 3/22/86

Charge for each service → \$40.00, \$60.00, \$40.00, \$25.00

Diagnosis code and procedure code → 401.9, 487.1, 727.3, 12002

PHARMACY BILLS

Pharmacy name and address → ORCHARD GROVE PHARMACY
300 Avocado Drive
Hometown, PA 15289

Full name of patient (Separate bill should be submitted for each member of family for whom benefits are being claimed.) → John Jones

Date: January 17, 1987

Date of purchase → January 17, 1987

Patient's Name JOHN JONES

RX #	Drug Name	Prescribed By	Charge
456322	AMPICILLIN	DR. SMITH	\$ 2.00
544655	INDERAL	DR. SMITH	\$ 4.75
510402	DARVOCET	DR. SMITH	\$16.57
			TOTAL

Drug name → AMPICILLIN, Inderal, DARVOCET

Prescription number → 456322, 544655, 510402

Prescribing physician's name → DR. SMITH

Separate charge for each prescription → \$ 2.00, \$ 4.75, \$16.57

NURSES BILLS

Hometown Nursing Bureau
Front & Main Sts.
Hometown, PA 15289

Date: 01-04-87

Full Name of Patient → John Jones (Patient's Name)

Nurse's name and status → Jane Smith, R.N. (Nurse's Name)

License # → 012345

Dates of Service → From 12-27-86 to 12-31-86

No. of shifts → 3 shifts

Length of shift → 7-3 pm @ 100.00

Chg. per shift → 100.00

Total \$300.00

Community Hospital-Rm 503 (Patient's Address)

PSYCHOLOGIST BILLS

Doctor's name, status & license # → Jane C. Jones, Ed.D.
Licensed Psychologist
PSO12345L

Doctor's address & telephone # → 123 Main St.
Hometown, PA 15289
555-1234 Hrs. by Appt.

Full name of patient → John Smith

For Professional Services to:

01-06-86—Psychological Test 90830—4 hrs.	\$300.00
01-13-86—Psychotherapy 90844	\$ 75.00
01-15-86—Group Psychotherapy 90853	\$ 35.00

Date and type of each treatment → 01-06-86, 01-13-86, 01-15-86

Chg. for each treatment → \$300.00, \$ 75.00, \$ 35.00

Diagnosis → DX-301.0

Please provide any information or additional circumstances which you feel might affect your claim.
