OUT-OF-NETWORK CLAIM FORM

I. MEMBER'S NAME (First, Middle, Last) IDENTIFICATION NUMBER GROUP NUMBER

PRESENT ADDRESS STREET □ NEW ADDRESS CITY STATE ZIP CODE

PATIENT'S NAME (First, Middle, Last) RELATIONSHIP OF PATIENT TO MEMBER SEX BIRTH DATE
□ SELF □ SPOUSE □ CHILD □ HANDICAPPED DEPENDENT □ OTHER □ MALE / / □ FEMALE / / / /

II. • Does the PATIENT have additional health insurance benefits? □ NO □ YES If yes, complete Part II:

POLICYHOLDER'S NAME BIRTH DATE EMPLOYMENT STATUS OF POLICYHOLDER
□ SELF □ SPOUSE □ CHILD □ OTHER OTHER INSURANCE CARRIER'S NAME IDENTIFICATION NO EFFECTIVE DATE
□ MALE □ FEMALE □ MALE □ FEMALE / / / /

RELATIONSHIP OF POLICYHOLDER TO MEMBER OTHER INSURANCE CARRIER'S NAME
□ SELF □ SPOUSE □ CHILD □ OTHER
□ MALE □ FEMALE □ MALE □ FEMALE / / / /

TYPE(S) OF COVERAGE
□ HOSPITALIZATION □ MEDICAL-SURGICAL □ DENTAL □ VISION □ DRUG □ MAJOR MEDICAL
□ OTHER

□ POLICYHOLDER ONLY □ POLICYHOLDER AND SPOUSE □ POLICYHOLDER AND CHILD(REN) □ FAMILY

• Is the PATIENT entitled to benefits under MEDICARE HOSPITALIZATION Insurance (Part A)?
□ NO □ YES EFFECTIVE DATE: / / / □ MEDICARE ID NUMBER

• Does the PATIENT receive benefits under MEDICARE MEDICAL Insurance (Part B)?
□ NO □ YES EFFECTIVE DATE: / / / □ MEDICARE ID NUMBER

If you answered "YES" to either of the above, give employment status of the member listed in Part I:
□ ACTIVE □ RETIRED □ DISABLED

III. • DESCRIBE CONDITIONS FOR WHICH YOU ARE REQUESTING BENEFITS AT THIS TIME:

TYPE OF INJURY/IllNESS NAME OF DOCTOR TREATING INJURY/IllNESS DATE OF FIRST SYMPTOMS

A. ____________________________________ ____________________________________ __________________________

B. ____________________________________ ____________________________________ __________________________

(Attach additional information, if necessary)

WERE SERVICES RELATED TO HOSPITALIZATION? □ NO □ YES If yes,
Give date of admission / / / Give date of discharge / / / Admitting Physician

WERE EXPENSES DUE TO AN ACCIDENT? □ NO □ YES If yes, give type/place of accident:
Give date of accident / / / □ Auto □ Work □ Other (specify)

IV. 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 Blue Cross all medical or other information requested for the processing of this claim. I hereby agree to reimburse Blue Cross in full should this claim be incorrectly paid. Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent act, which is a crime and subjects such person to criminal and civil penalties.

MEMBER'S SIGNATURE DATE (AREA CODE) HOME PHONE (AREA CODE) WORK PHONE

1519D 8/99
INSTRUCTIONS:

Remember: Personal Choice Network providers will submit a claim for you. This claim form should only be used when you see an Out-of-Network provider who does not submit a claim for you.

1. Attach all itemized bills to this claim form. Bills should include the following information:
   - Name, address, and telephone number (on official bill head) of the PROVIDER rendering the service or supplying the item.
   - PATIENT’S full name
   - DESCRIPTION of each service, or supply
   - DATE AND AMOUNT CHARGED for each service, or supply
   - DIAGNOSIS

2. When you have already paid the out-of-network provider in full for the services, or supplies you are claiming, payment should be made to you (if you are our member). Please be sure to have the provider mark “PAID IN FULL” clearly on the bill.

3. Please be sure that a PHYSICIAN’S MEDICAL CERTIFICATION accompanies bills for:
   - Purchase or Rental of Medical Equipment

4. If submitting expenses for more than one family member, please use a SEPARATE claim form for each person.

5. Complete the entire claim form (have your physician complete the appropriate section, if necessary) and be sure to include the information requested above. This will avoid unnecessary delays in processing your claim. Keep a copy of this form and itemized bills for your records.

6. If you have QUESTIONS regarding the completion of this claim form, please contact Personal Choice Member Services at the telephone numbers shown on your ID card.