FOR OFFICE USE ONLY

HEALTH BENEFITS CLAIM FORM

Healthcare benefit programs issued or administered by Capital Blue Cross and/or its subsidiaries, Capital Advantage Insurance Company®, Capital Advantage Assurance Company® and Keystone Health Plan® Central. Independent licensees of the Blue Cross Blue Shield Association serving 21 counties in Central Pennsylvania and the Lehigh Valley. Communications issued by Capital Blue Cross in its capacity as administrator of programs and provider relations for all companies.

Columbia Service Center
P.O. Box 100121
Columbia, SC 29202-3121

1 **Employee's** Name ______________________

Identification Number ______________________
(Please include the letters if included on your ID card)

2 **Patient's** Name ______________________
First Middle Initial Last

3 The **Patient** is: ☐ Female ☐ Male

And is the: ☐ Employee ☐ Employee's Spouse ☐ Employee's Child

4 **Patient's** Date of Birth Month __ __ Day __ __ Year __ __

5 **Employee's** Mailing Address ☐ Check if new address
____
Street City State ZIP Code

6 Was any treatment required as a result of accidental injury? ☐ Yes ☐ No Date of accident ______________

7 If an accident, was another person at fault? ☐ Yes ☐ No If yes, please explain below.
____

Was any injury or illness work related? ☐ Yes ☐ No

8 Is the patient covered by Medicare Part A? ☐ Yes ☐ No
Or by Medicare Part B? ☐ Yes ☐ No
If yes, please attach your Explanation of Medicare Benefits (EOMB). It is necessary to process this claim.
Medicare Health Insurance Benefit Number: ______________________

9 Is the patient covered under any other health benefit plan? ☐ Yes ☐ No
If yes, please attach your Explanation of Benefits (EOB) from the other insurance company. Also, please complete this entire section as it is necessary to process this claim.

A. Policyholder's Name ______________________

Relationship of Policyholder to Patient ______________________

B. Name of Other Policyholder's Employer ______________________

Address of Other Policyholder's Employer ______________________
City State ZIP Code

C. Name of Other Insurance Company ______________________

Address of Other Insurance Company ______________________

10 CERTIFICATION OF MEMBER

I certify that the above information is correct and that the foregoing expenses were incurred for the above named patient. I request eligible benefits for these expenses. I authorize any physician, nurse, hospital, or other provider or supplier in possession of records or information concerning the patient to furnish such information to my health plan or its administrator upon request. (Be sure to complete items 1–9 on this form and **attach itemized statements for all expenses. Absence of this information may cause a delay in processing this claim.**)

Date ______________ Employee's Signature ______________________

EXAMPLES OF
PHYSICIANS, MEDICAL EQUIPMENT, PHARMACIST, AND NURSING BILLS

The following are properly filed itemized bills with the required information needed to process your claim.

PHYSICIANS BILLS

- A - Physician name, Tax ID# (TIN) and address.
- B - Full name of patient should appear on every bill, not just name of person paying bill.
- C - The date of medical treatment.
- D - Procedure code(s) for type of medical treatment.
- E - Diagnosis (ICD) code.
- F - Separate cost for each treatment.

(A) **Harry Smith, M.D. (123-45-6789)**
Columbia, S.C.

Patient
John Jones (B) (C) 9/18/95 - 9/23-75

(D) Surgery, Appendectomy Procedure (CPT) code: 44960 (E) Diagnosis: Appendicitis Diagnosis Code: 540.9	(F) 250.00 No Charge No Charge 15.00 5.00
Please provide	

MEDICAL EQUIPMENT BILLS

ACE BRACE Co.
Columbia, S.C.

(A) **Patient** Nancy Smith	(C) **Date** 9/17/95
(A) **Address** 2905 Start Rd.	(A) **Phone** 788-1234
(B) Dr. Jones	(D) Diabetes – 250.92

Quantity	Medical Equipment Purchased	Price
1	(E) Wheelchair - Economy	299.00
	(F) Code: E113	
	Tax	11.96
		310.96

Note: A letter of medical necessity is required for medical equipment purchase(s) before major medical will process.

- A - Full name of patient, address and telephone #.
- B - Name of doctor ordering medical equipment.
- C - Date medical equipment purchased.
- D - Diagnosis code(s).
- E - Description of equipment purchased.
- F - Procedure code(s) of equipment purchased.

PHARMACIST BILLS

- A - Full name of patient. (Separate bill should be submitted for each member of family for whom major medical expense benefits are being claimed.)
- B - Diagnosis code(s).
- C - Date of purchase.
- D - Prescription number, quantity, name and strength of drug.
- E - Separate charge for each prescription.
- F - Pharmacist's signature.

PRICE PHARMACY

200 Market Street
Columbia, S.C.

(A) Mary G. Jones (B) Hypertension – 401.9

Date	Prescription Number Description	Charge
(C) 8/31/95	(D) 575-516 60 Aldoril25mg Dr. G.S. Smith	(E) 11.60
	588-152 60 HCTZ50mg Dr. G.S. Smith	7.25
10/1/95	592-321 30 Aldoril25mg Dr. G.S. Smith	6.20
12/9/95	599-472 60 Aldoril25mg Dr. G.S. Smith	11.60
(F) *G.S. Smith*		36.65

NURSING BILLS

(A) **NURSE** Diane Smith RN	(A) **LICENSE OR REGISTRY NO.** 12345
(B) **FOR** Mr. Ed Johnson	(C) **PLACE OF TREATMENT** Home Care

(D) Stroke – 250.92

(B) **ADDRESS** 123 2nd St., Columbia, S.C.

DATES WORKED	SHIFT/HOURS	CHARGE
(E) 12/8/95	(F) 7-3 p.m./8 hrs.	
12/9/95	7-3 p.m./8 hrs.	40.00
12/10/95	11-7 a.m./8 hrs.	40.00
TOTAL HOURS	24 hrs.	

- A - Nursing bills must clearly indicate whether the nurse is a Registered Nurse (RN) or Licensed Practical Nurse (LPN). Also the license or registry number.
- B - Name and address of patient.
- C - Were nursing services provided in hospital, home or elsewhere?
- D - Diagnosis code(s).
- E - Dates worked.
- F - Shift and/or hours worked.

On any of the above forms, please provide proof of payment if patient has paid.

Non-Discrimination Statement and Foreign Language Access

We do not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation or health status in our health plans, when we enroll members or provide benefits.

If you or someone you're assisting is disabled and needs interpretation assistance, help is available at the contact number posted on our website or listed in the materials included with this notice (TDD: 711).

Free language interpretation support is available for those who cannot read or speak English by calling one of the appropriate numbers listed below.

If you think we have not provided these services or have discriminated in any way, you can file a grievance by emailing contact@hcrcompliance.com or by calling our Compliance area at 1-800-832-9686 or the U.S. Department of Health and Human Services, Office for Civil Rights at 1-800-368-1019 or 1-800-537-7697 (TDD).

Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de este plan de salud, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-844-396-0183. (Spanish)

如果您，或是您正在協助的對象，有關於本健康計畫方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥 1-844-396-0188。(Chinese)

Nếu quý vị, hoặc là người mà quý vị đang giúp đỡ, có những câu hỏi quan tâm về chương trình sức khỏe này, quý vị sẽ được giúp đở với các thông tin bằng ngôn ngữ của quý vị miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-844-389-4838 (Vietnamese)

이 건강보험에 관하여 궁금한 사항 혹은 질문이 있으시면 1-844-396-0187로 연락해 주십시오. 귀하의 비용 부담없이 한국어로 도와드립니다. (Korean)

Kung ikaw, o ang iyong tinutulungan, ay may mga katanungan tungkol sa planong pangkalusugang ito, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika nang walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-844-389-4839. (Tagalog)

Если у Вас или лица, которому вы помогаете, имеются вопросы по поводу Вашего плана медицинского обслуживания, то Вы имеете право на бесплатное получение помощи и информации на русском языке. Для разговора с переводчиком позвоните по телефону 1-844-389-4840. (Russian)

إن كان لديك أو لدى شخص تساعده أسئلة بخصوص خطة الصحة هذه، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة.للتحدث مع مترجم اتصل ب 1-844-396-0189 (Arabic)

Si ou menm oswa yon moun w ap ede gen kesyon konsènan plan sante sa a, se dwa w pou resevwa asistans ak enfòmasyon nan lang ou pale a, san ou pa gen pou peye pou sa. Pou pale avèk yon entèprèt, rele nan 1-844-398-6232. (French/Haitian Creole)

Si vous, ou quelqu'un que vous êtes en train d'aider, avez des questions à propos de ce plan médical, vous avez le droit d'obtenir gratuitement de l'aide et des informations dans votre langue. Pour parler à un interprète, appelez le 1-844-396-0190. (French)

Jeśli Ty lub osoba, której pomagasz, macie pytania odnośnie planu ubezpieczenia zdrowotnego, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer 1-844-396-0186. (Polish)

Se você, ou alguém a quem você está ajudando, tem perguntas sobre este plano de saúde, você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para falar com um intérprete, ligue para 1-844-396-0182. (Portuguese)

Se tu o qualcuno che stai aiutando avete domande su questo piano sanitario, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare 1-844-396-0184. (Italian)

あなた、またはあなたがお世話をされている方が、この健康保険 についてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、1-844-396-0185 までお電話ください。 (Japanese)

Falls Sie oder jemand, dem Sie helfen, Fragen zu diesem Krankenversicherungsplan haben bzw. hat, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-844-396-0191 an. (German)

اگر شما یا فردی که به او کمک می کنید سؤالاتی در بارهٔ این برنامهٔ بهداشتی داشته باشید، حق این را دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت کنید. برای صحبت کردن با مترجم، لطفاً با شمارهٔ 1-844-398-6233 تماس حاصل نمایید. (Persian-Farsi)

Ni da doodago t'áá háída bíká'aná nílwo'ígíí díí Béeso Ách'ą́ą́h naa'nilígi háá'ída yí na' ídíł kidgo, nihá'áhóót'i' nihí ká'a'doo wołgo kwii ha'át'íshį́į́ bí na'ídołkidígi doo bik'é'azláagóó. Ata' halne'é ła' bich'į' ha desdzih nínízingo, kojį' béésh bee hólne' 1-844-516-6328. (Navajo)

Vann du adda ebbah es du am helfa bisht, ennichi questions hend veyyich *deah health plan*, hend diah's recht fa hilf un information greeya in eiyah aykni shprohch unni kosht. Fa shvetza mitt en interpreter, roof deah nummah oh 1-833-584-1829. (Pennsylvania Dutch)