

Claim Form

To pay Insured/Subscriber

Each item on this form needs to be completed.
Instructions for completion are listed on the reverse side.

Please print or type.

1	Insured/Subscriber Name (Last, First, Middle Initial)			2	Group Number		Insured/Subscriber Identification Number (from ID card)		
	Mailing Address				Patient's Full Name (Last, First, Middle)				
	City and State		ZIP Code	Patient's Sex		Patient's Date of Birth			Month Day Year
	Insured Employed?		Date of Retirement:						
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Retired		Month Day Year		<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other (explain) _____					

3	Type of treatment received:			Month Day Year
	Check only one type and attach itemized statements. Please use a separate claim form for each different type of treatment.			
	Please note: Preventive care includes immunizations, routine well baby care, routine physical examinations, vision and hearing exams.			
	<input type="checkbox"/> Injury — Date of accident:	_____ / _____ / _____		
	<input type="checkbox"/> Illness — Date of first symptom:	_____ / _____ / _____		
<input type="checkbox"/> Pregnancy — Date of conception:	_____ / _____ / _____			
<input type="checkbox"/> Preventive — Date of service:	_____ / _____ / _____			

4	Describe: Diagnosis, symptoms of illness or injury or explain preventive or routine care received.

5	Was illness or injury work connected? <input type="checkbox"/> Yes <input type="checkbox"/> No	Name and address of employer
6	If injury, was a motor vehicle involved? <input type="checkbox"/> Yes <input type="checkbox"/> No	_____

7	Is patient covered under any other health benefits plan (besides Medicaid, Medicare or CHAMPUS)? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Insurance Co. _____		Month Day Year	
Address _____		Effective date of coverage	_____ / _____ / _____
Employer _____		Sex of Insured <input type="checkbox"/> Male <input type="checkbox"/> Female	
Insured name _____		Date of birth of insured	_____ / _____ / _____
Policy # _____		Relationship to patient	_____
If the other coverage is primary, attach the other insurance company's Explanation of Benefits.			

8	Medicare — Is the patient:			Month Day Year
	a) Entitled to benefits under Medicare insurance (Part A)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Effective	_____ / _____ / _____
	b) Entitled to benefits under Medicare insurance (Part B)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Effective	_____ / _____ / _____
	c) Entitled to benefits under Medicare due to a disability?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Effective	_____ / _____ / _____
Patient's Medicare Identification Number. (From Medicare ID card) _____				

9	I certify the above is complete and correct and that I am claiming benefits only for charges incurred by the patient named above. Authorization is hereby given to any Hospital, Physician, Dentist, Provider, Insurance Carrier or other entity to give Blue Cross and Blue Shield of Texas, upon request, any medical information. Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.		
	Signature of Insured	Date	Daytime telephone number
_____			_____

10	Total amount for ALL covered services and supplies received.	\$
Itemized Bill(s) for covered services and supplies must be attached. (See Instructions on reverse side.)		

INSTRUCTIONS

Important: DO NOT file this form if your Provider of Service is submitting these charges to Blue Cross and Blue Shield of Texas.

Please complete every item on claim form.

1	Insured/subscriber's name, address and employment status	Please show the insured/subscriber's name exactly as it appears on the Blue Cross and Blue Shield of Texas identification card and specify the current address including the ZIP code. Check appropriate box indicating the insured/subscriber's employment status. If retired, give date of retirement.
2	Patient information	Make sure the group number and identification number are exactly as shown on the insured's identification card. List patient's full name; no nicknames or initials. Check the appropriate blocks for the patient's sex and relationship to the insured. Ensure the patient's correct date of birth is shown.
3	Type of treatment received	Check only one treatment type (injury, illness, pregnancy or preventive care) and specify date of injury, date of first symptom, date of conception or date preventive care was received. You may attach multiple itemized statements if they are for one type of treatment (example: illness only, preventive care only).
4	Diagnosis or symptoms of illness or injury	Give diagnosis or a brief description of symptoms. If preventive care services were received, state the type of care (routine physical, hearing exam, vision exam, immunization or diagnosis, etc.).
5	If illness or injury is in any way work-related	Check appropriate box and enter name and address of employer.
6	If motor vehicle injury	Check appropriate box.
7	Other insurance	Please check appropriate box. If "yes," complete the required information.
8	Medicare information	Please check appropriate box concerning Medicare eligibility. If "yes," show effective date and give Medicare identification number. Medicare Enrollees should include a copy(s) of the Medicare Explanation of Benefits Form(s) (EOB) with their itemized statements unless patient is actively employed and requires group coverage to pay primary.
9	Insured's signature, date and daytime telephone number	Please sign and date this form and attach your physician's itemized letterhead statement(s). The itemized statement(s) should contain all the information shown in the following example:

Example of Itemized Bill — Please remember to attach the original bill(s) to the claim form and make a copy for your records. Itemized bills cannot be returned.

Name of the person or organization providing the services or supplies.

Dayton Penridge, M.D.
101 Fourth Street
Healthville, U.S.A.

For Professional Services Rendered To: Virginia E. Warowes Diagnosis Code: (78659) Chest pain, other

3/1/15	G0206 Mammogram	\$XXX
3/1/15	19120 Excision of Cyst	\$XXX
3/1/15	19083 Biopsy, breast w/ Ultrasound	\$XXX
3/6/15	90659 Flu Vaccine	\$XXX
3/6/15	G0008 Flu Vaccine Administration	\$XXX

If you are submitting itemized bills for a variety of services please use a separate claim form for each different type of treatment (one for illness, another for an injury, etc.).

Name of the patient receiving the services or supplies

Date each service or supply was provided Description of the services or supplies provided Charge for each service or supply

Please cross out those charges which were included on a previous claim.

NOTE: Bills for Private Duty Nursing Service must show the professional status of the nurse (R.N. — Registered Nurse, L.V.N. — Licensed Vocational Nurse), the nurse's license number, and must be accompanied by a statement from your physician indicating medical necessity and daily nurse's progress notes.

FOR OTHER THAN PRESCRIPTION DRUG CARD HOLDERS: Bills for Prescription Drugs must show the name of each drug, the prescription number, the quantity dispensed, the date of purchase, and the amount charged for each drug. If drug is generic then the pharmacist must also indicate on itemized bill.

This completed form, together with the itemized bills, should be submitted to:

Blue Cross and Blue Shield of Texas
PO Box 660044
Dallas, Texas 75266-0044

Non-Discrimination Notice

Health Care Coverage Is Important For Everyone

We do not discriminate on the basis of race, color, national origin (including limited English knowledge and first language), age, disability, or sex (as understood in the applicable regulation). We provide people with disabilities with reasonable modifications and free communication aids to allow for effective communication with us. We also provide free language assistance services to people whose first language is not English.

To receive reasonable modifications, communication aids or language assistance free of charge, please call us at 800-252-8039.

If you believe we have failed to provide a service, or think we have discriminated in another way, you can file a grievance with:

Office of Civil Rights Coordinator	Phone: 855-664-7270 (voicemail)
Attn: Office of Civil Rights Coordinator	TTY/TDD: 855-661-6965
300 E. Randolph St., 35th Floor	Fax: 855-661-6960
Chicago, IL 60601	Email: CivilRightsCoordinator@bcbsil.com

You can file a grievance by mail, fax or email. If you need help filing a grievance, please call the toll-free phone number listed on the back of your ID card (TTY: 711).

You may file a civil rights complaint with the US Department of Health and Human Services, Office for Civil Rights, at:

Centralized Case Management Operations	Phone: 800-368-1019
US Dept of Health & Human Services	TTY/TDD: 800-537-7697
200 Independence Avenue SW	Complaint Portal:
Room 509F, HHH Building	ocrportal.hhs.gov/ocr/smartscreen/main.jsf
Washington, DC 20201	Complaint Forms:
Email: OCRComplaint@hhs.gov	hhs.gov/civil-rights/filing-a-complaint/index.html

This notice is available on our website at healthselect.bcbstx.com/important-info/non-discrimination-notice

ATTENTION: If you speak another language, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 800-252-8039 (TTY: 711) or speak to your provider.

Español Spanish	ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 800-252-8039 (TTY: 711) o hable con su proveedor.
Việt Vietnamese	LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 800-252-8039 (Người khuyết tật: 711) hoặc trao đổi với người cung cấp dịch vụ của bạn.



中文 Chinese	注意：如果您说中，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。致电 800-252-8039（文本电话：711）或咨询您的服务提供者。
한국어 Korean	주의: 한국어를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 800-252-8039 (TTY: 711) 번으로 전화하거나 서비스 제공업체에 문의하십시오.
العربية Arabic	تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم 800-252-8039 (TTY: 711) أو تحدث إلى مقدم الخدمة.
اردو Urdu	توجہ دیں: اگر آپ اردو بولتے ہیں، تو آپ کے لیے زبان کی مفت مدد کی خدمات دستیاب ہیں۔ قابل رسائی فارمیٹس میں معلومات فراہم کرنے کے لیے مناسب معاون امداد اور خدمات بھی مفت دستیاب ہیں۔ (800-252-8039 (TTY: 711) پر کال کریں یا اپنے فراہم کنندہ سے بات کریں۔
Tagalog Tagalog	PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 800-252-8039 (TTY: 711) o makipag-usap sa iyong provider.
Français French	ATTENTION : Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 800-252-8039 (TTY : 711) ou parlez à votre fournisseur.
हिंदी Hindi	ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपके लिए नि:शुल्क भाषा सहायता सेवाएं उपलब्ध होती हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएं भी नि:शुल्क उपलब्ध हैं। 800-252-8039 (TTY: 711) पर काल करें या अपने प्रदाता से बात करें।
فارسی Persian	توجه: اگر فارسی صحبت می کنید، خدمات پشتیبانی زبانی رایگان در دسترس شما قرار دارد. همچنین کمک ها و خدمات پشتیبانی مناسب برای ارائه اطلاعات در قالب های قابل دسترس، به طور رایگان موجود می باشند. با شماره 800-252-8039 (تله تایپ: 711) تماس بگیرید یا با ارائه دهنده خود صحبت کنید.
Deutsch German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistentendienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 800-252-8039 (TTY: 711) an oder sprechen Sie mit Ihrem Provider.
ગુજરાતી Gujarati	ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો તો મફત ભાષાકીય સહાયતા સેવાઓ તમારા માટે ઉપલબ્ધ છે. યોગ્ય ઓફિસિયલ સહાય અને એક્સેસિબલ ફોર્મેટમાં માહિતી પૂરી પાડવા માટેની સેવાઓ પણ વિના મૂલ્યે ઉપલબ્ધ છે. 800-252-8039 (TTY: 711) પર કોલ કરો અથવા તમારા પ્રદાતા સાથે વાત કરો.
РУССКИЙ Russian	ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 800-252-8039 (TTY: 711) или обратитесь к своему поставщику услуг.
日本語 Japanese	注: 日本語を話される場合、無料の言語支援サービスをご利用いただけます。アクセシブル(誰もが利用できるよう配慮された)な形式で情報を提供するための適切な補助支援やサービスも無料でご利用いただけます。800-252-8039 (TTY: 711)までお電話ください。または、ご利用の事業者にご相談ください。
ລາວ Laotian	ຄຳຂໍ້ມູນ: ຖ້າທ່ານເວົ້າພາສາ ລາວ, ຈະມີບໍລິການຊ່ວຍດ້ານພາສາແບບບໍ່ເສຍຄ່າໃຫ້ທ່ານ. ມີເຄື່ອງຊ່ວຍ ແລະ ການບໍລິການແບບບໍ່ເສຍຄ່າທີ່ໝາະສົມເພື່ອໃຫ້ຂໍ້ມູນໃນຮູບແບບທີ່ສາມາດເຂົ້າເຖິງໄດ້. ໂທຫາເບີ 800-252-8039 (TTY: 711) ຫຼື ລົມກັບຜູ້ໃຫ້ບໍລິການຂອງທ່ານ.
Diné Navajo	SHOOH: Diné bee yáníłti'gogo, saad bee aná'awo' bee áka'anída'awo'ít'áá jiik'eh ná hóló. Bee ahít hane'go bee nida'anishí t'áá ákodaat'éhígíí dóó bee áka'anída'wo'í áko bee baa hane'í bee hadadilyaa bich'í' ahoot'i'ígíí éí t'áá jiik'eh hóló. Kohjí' 800-252-8039 (TTY: 711) hodílnih doodago nika'análwo'í bich'í' hanidziih.