BlueCross BlueShield of Illinois

Claim Form
to Pay Insured/Subscriber

P.O. Box 805107 • Chicago, Illinois 60680-4112

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)

Mailing Address

City and State | **ZIP Code**

Insured Employed?
☐ Yes ☐ No ☐ Retired
Date of Retirement (MM/DD/YYYY): _____/_____/_____

2

Group Number | **Insured/Subscriber Identification Number** (from ID card)

Patient's Full Name (Last, First, Middle)

Patient's Sex
☐ Male ☐ Female

Patient's Date of Birth (MM/DD/YYYY):
_____/_____/_____

Patient's Relationship to Insured
☐ Self ☐ Spouse ☐ Child ☐ Other (explain) _____

3

Provider Name and Address _____

Provider Tax ID# _____ Provider NPI# _____

Type of treatment received:
Check only one type and attach itemized statements. Please use a separate claim form for each different type of treatment.

☐ Injury — Date of accident (MM/DD/YYYY): _____/_____/_____
☐ Illness — Date of first symptom (MM/DD/YYYY): _____/_____/_____
☐ Pregnancy — Date of conception (MM/DD/YYYY): _____/_____/_____
☐ Preventive — Date of service (MM/DD/YYYY): _____/_____/_____

4

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

_____
_____
_____

5

Was illness or injury work connected? ☐ Yes ☐ No

Name and address of employer

_____
_____

6

If injury, was a motor vehicle involved? ☐ Yes ☐ No

7

Is patient covered under any other health benefits plan (besides Medicaid, Medicare or CHAMPUS)? ☐ Yes ☐ No

Insurance Co. _____
Address _____
Employer _____
Insured name _____
Policy # _____

Effective date of coverage (MM/DD/YYYY): _____/_____/_____
Sex of Insured ☐ Male ☐ Female
Date of birth of insured (MM/DD/YYYY): _____/_____/_____
Relationship to patient _____

If the other coverage is primary, attach the other insurance company's Explanation of Benefits.

8

Medicare — Is the patient:

a) Entitled to benefits under Medicare insurance (Part A)? ☐ Yes ☐ No Effective (MM/DD/YYYY): _____/_____/_____
b) Entitled to benefits under Medicare insurance (Part B)? ☐ Yes ☐ No Effective (MM/DD/YYYY): _____/_____/_____
c) Entitled to benefits under Medicare due to a disability? ☐ Yes ☐ No Effective (MM/DD/YYYY): _____/_____/_____

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 Illinois, upon request, any medical information which the Plans in their judgment deem necessary to the adjudication of this claim. Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Signature of Insured	**Date**	**Daytime telephone number**

10

Total amount for ALL covered services and supplies received.	**$**

Itemized Bill(s) and proof of payment for covered services and supplies must be attached. ***(See Instructions on reverse side.)***

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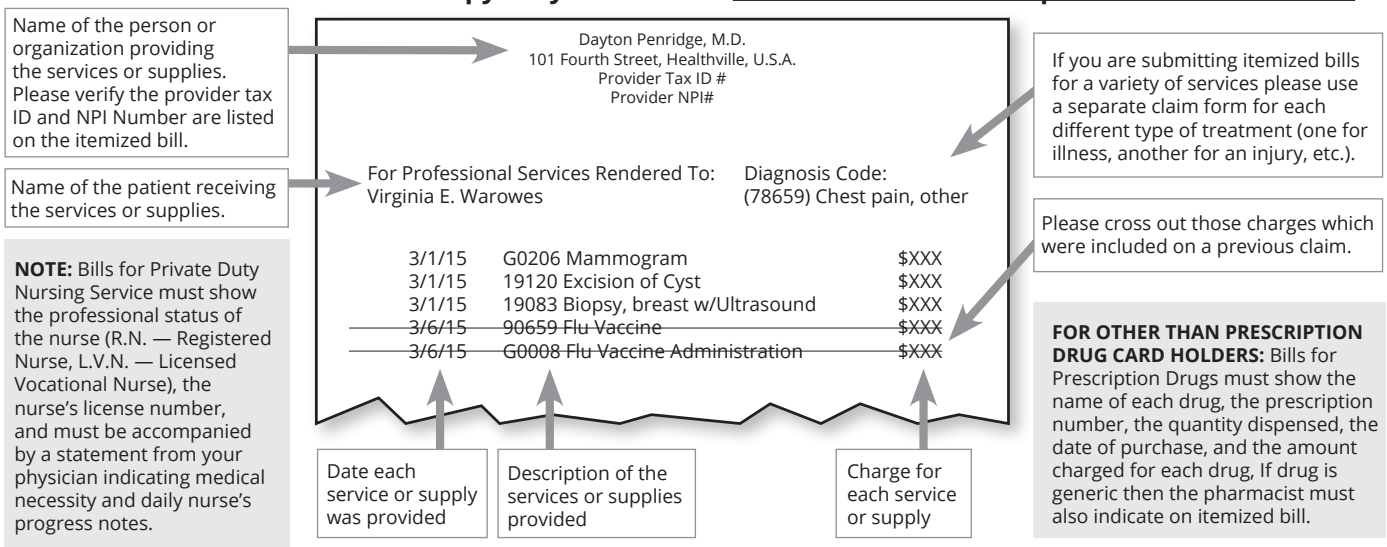
INSTRUCTIONS

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

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 Illinois 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	Provider Information Type of treatment received	Name, address, Tax ID and NPI number of the person or organization providing the services or supplies. 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:
10		**<u>Example of Itemized Bill</u> — Please remember to attach the original bill(s) and proof of payment to the claim form and make a copy for your records. <u>Itemized bills and receipts cannot be returned.</u>**



This completed form, together with the itemized bills and proof of payment including copy of patient paid receipt or invoice showing zero balance, should be submitted to:

Blue Cross and Blue Shield of Illinois
P.O. Box 805107
Chicago, Illinois 60680-4112