



# HEALTH BENEFITS CLAIM FORM

SEE INSTRUCTIONS ON REVERSE SIDE

## PATIENT INFORMATION A SEPARATE CLAIM FORM MUST BE COMPLETED FOR EACH PATIENT

LAST NAME OF PATIENT	FIRST	MIDDLE INITIAL	SEX <input type="checkbox"/> M <input type="checkbox"/> F	RELATIONSHIP TO MEMBER	DATE OF BIRTH (MM/DD/YY)
----------------------	-------	----------------	--	------------------------	--------------------------

## MEMBER INFORMATION

LAST NAME OF MEMBER	FIRST	MIDDLE INITIAL	EMPLOYER
MEMBER'S ADDRESS (STREET, CITY, STATE, ZIP CODE)			

## IDENTIFICATION NUMBER COPY THIS FROM YOUR BLUE CROSS AND BLUE SHIELD IDENTIFICATION CARD

IDENTIFICATION NUMBER (FROM BLUE CROSS AND BLUE SHIELD CARD)	GROUP NUMBER
--	--------------

## ACCIDENT INFORMATION

IS CLAIM FOR ACCIDENTAL INJURY? <input type="checkbox"/> YES <input type="checkbox"/> NO	WAS ACCIDENTAL INJURY WORK RELATED? <input type="checkbox"/> YES <input type="checkbox"/> NO	DATE OF ACCIDENTAL INJURY
WHERE DID THE ACCIDENTAL INJURY OCCUR?		
DESCRIBE THE TYPE OF ACCIDENTAL INJURY		

## DESCRIPTION OF ILLNESS

BRIEFLY DESCRIBE THE CONDITIONS FOR WHICH SERVICES WERE RENDERED OR DRUGS PRESCRIBED

## OTHER INSURANCE INFORMATION

DOES PATIENT HAVE OTHER HEALTH INSURANCE? <input type="checkbox"/> YES <input type="checkbox"/> NO	COVERAGE IS: <input type="checkbox"/> SINGLE <input type="checkbox"/> FAMILY	MEDICARE? <input type="checkbox"/> YES <input type="checkbox"/> NO	
POLICY HOLDER'S NAME	OTHER INSURANCE CARRIER'S NAME	POLICY NUMBER	EFFECTIVE DATE OF COVERAGE (MM/DD/YY)
OTHER INSURANCE CARRIER'S PHONE NUMBER	OTHER INSURANCE CARRIER'S ADDRESS		

## AGREEMENT AND SIGNATURE OF MEMBER CLAIM WILL NOT BE ACCEPTED WITHOUT SIGNATURE OF MEMBER

I certify that the above information is correct and that the bills attached were incurred by the patient listed above. I authorize any medical professional, hospital, medical or medically related facility, pharmacy, government agency, insurance company or other person or firm to provide Blue Cross and Blue Shield information, including copies of records, concerning advice, care or treatment provided the patient above including, without limitation, information relating to mental illness, use of drugs or alcohol, upon presentation of a photocopy of this signed authorization. I understand that such information will be used by Blue Cross and Blue Shield for the purpose of evaluating a claim for insurance benefits for services provided to the patient named above, I understand that I or any authorized representative will receive a copy of this authorization upon request. This authorization is valid from the date signed until revoked in writing.

MEMBER'S SIGNATURE X	MEMBER'S DAYTIME PHONE NUMBER	DATE SIGNED (MM/DD/YY)
-------------------------	-------------------------------	------------------------

# Follow these steps for fast, efficient service!

1. Please remember to present your Blue Cross and Blue Shield of Oklahoma identification card whenever you receive health care services.
2. Claims for both inpatient and outpatient hospital services must be submitted **by the hospital** directly to Blue Cross and Blue Shield of Oklahoma.
3. Physicians and certain other health care providers who are members of Blue Cross and Blue Shield of Oklahoma's participating provider network (PAR-NET, PPO, Primary Care Physician) also will file your claim for you. **If your doctor or other health care provider files your claim, it's important NOT to file the same claim yourself. Duplicate claims will delay processing.**
4. If you need to file your own claim, please complete the reverse side of this form. **You can help us avoid processing delays by answering all the questions completely. Be sure to complete a separate claim form for EACH patient.**
5. **Do you have other group health insurance or Medicare?**  
If so, and the other insurance carrier is primary (meaning that carrier pays first), you will need to file the claim with that carrier first. After you receive an "Explanation of Benefits" form from the other carrier (or Medicare), send a copy of it, copies of your itemized medical statements and a completed claim form to Blue Cross and Blue Shield of Oklahoma for processing.
6. **Always remember to include an itemized statement from your physician or other health care provider.** Be sure to keep a copy for your files. Balance due statements, payments on account, cancelled checks, receipts and ledger cards are not accepted.

Statements for **medical care** should include:

- Provider's name, address and telephone number
- Full name of patient (bills listing only the party responsible for payment are not acceptable)
- Place where service was rendered (hospital, emergency room, physician's office)
- Diagnosis of illness or accidental injury for each service rendered (if accidental injury, give the date it occurred)
- Date, description and charge for each service rendered

Statements for **prescription drugs** should include:

- Name and address of pharmacy
- Full name of patient
- Date of purchase
- Name of drug purchased and prescription number
- Total charge for each prescription

**A diagnosis of illness for which each drug was prescribed is required on "Description of Illness" section on front of claim form; a separate statement is required for each drug; cash register/credit card receipts or personal listings of drugs purchased cannot be accepted.**

Statements for **ambulance service** should include:

- Date the service was rendered
- Base rate and mileage
- Place where patient was picked up and final destination
- Date of admittance to hospital
- Indicate if the ambulance service was due to accidental injury. If so, provide the date of the accidental injury
- If not accidental injury related, type of illness

Statements for rental/purchase of **durable medical equipment** should include:

- The charge for equipment and whether it is being purchased or rented. (The cost to purchase the equipment should also be indicated on a rental claim. If the equipment is for long-term use, please remember that rental of durable medical equipment is paid only up to the purchase price of the equipment.)
- Prescription and letter of medical necessity from the attending physician which includes the length of time the equipment will be medically necessary.

7. If you have questions or would like to report a change of address, please call a Blue Cross and Blue Shield of Oklahoma Customer Service Representative in Tulsa at (918) 560-3500 or in Oklahoma City at (405) 841-9596. Call Monday through Friday from 9 a.m. to 4:30 p.m.
8. Please mail claim forms and statements to:  
BLUE CROSS AND BLUE SHIELD OF OKLAHOMA