

1 **Employee's**
Name _____
Identification
Number _____
(Please include the letters if included on your ID Card)

FOR OFFICE USE ONLY

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

**HEALTH BENEFITS
CLAIM FORM**

3 The **Patient** is: Female Male
And Is The:
Employee Employee's Spouse Employee's Child



**BlueCross BlueShield
of Florida**

An Independent Licensee of the
Blue Cross and Blue Shield Association

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

www.MyInsuranceManager.com/FL

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

5 **Employee's** Check if New Address
Mailing 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 Health Insurance, Part A? Yes No
Or by Supplemental Medical Insurance, Part B? Yes No
If yes, please attach your "Explanation of Medicare Benefits." It is necessary to process this claim.
Complete the following Medicare Health Insurance Benefit Number # _____

Is the patient covered under any other health benefit plan? Yes No

If yes, please attach your "Explanation of Benefits" from the other Insurance Company. Also, please complete this entire section as it is necessary to process this claim.

9 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 _____

CERTIFICATION OF MEMBER

10 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

**MEDICAL AND SURGICAL BILLS
SHOULD INCLUDE THE FOLLOWING:**

| | |
|---|-------------------|
| (A) Harry Smith, M.D. Columbia, S.C. | |
| Patient John Jones (B) | |
| (C) 9/18/95 Surgery, Appendectomy (D) | (E) 250.00 |
| 9/17 - 23/95 Hospital Calls (D) | No Charge |
| (C) 10/23/95 (D) Office Call | No Charge |
| 12/1/95 Office Call—Virus (D) | 15.00 |
| | Injection |
| | 5.00 |

| | | |
|---|---------------------------------|--------------|
| ACE BRACE Co. Columbia, S.C. | | |
| (A) Patient Nancy Smith | (C) Date 9/17/95 | |
| Address 2905 Start Rd. Phone 788-1234 | | |
| Dr. Jones (B) | | |
| Quantity | Rx | Price |
| 1 | Wheelchair - Economy (D) | 299.00 |
| | TAX | 11.96 |
| | | 310.96 |

**MEDICAL EQUIPMENT
SHOULD INCLUDE THE FOLLOWING:**

- (A)** Full name of patient.
 - (B)** Name of Doctor ordering Medical Equipment.
 - (C)** Date Medical Equipment purchased.
 - (D)** Description of equipment purchased.
- Note:** Letter of medical necessity is required before major medical will process.

**DRUGGIST BILLS*
SHOULD INCLUDE THE FOLLOWING:**

| | | |
|--|---|------------------|
| PRICE PHARMACY 200 Market Street Columbia, S.C. | | |
| Patient: | | |
| (A) Mary G. Jones | Prescription | |
| Date | Number Description | Charge |
| (B) 8/31/95 | (C) 575-516 60 Aldoril25mg Dr. G.S. Smith | (D) 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 |
| (E) | | 36.65 |

- (A)** Physician name and address.
- (B)** Full name of patient should appear on every bill, not just name of person paying bill.
- (C)** The date of surgery or medical treatment.
- (D)** The type of surgery performed or type of medical treatment.
- (E)** Separate cost for each treatment.

- (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)** Date of purchase.
- (C)** Prescription number, quantity, name and strength of drug.
- (D)** Separate charge for each prescription.
- (E)** Pharmacist's signature.

**NURSING BILLS
SHOULD INCLUDE THE FOLLOWING:**

| | | |
|---|--------------------------------|----------------------|
| (A) Nurse Diane Smith RN | LICENSE OR REGISTRY NO. | (A) 12345 |
| (B) FOR Mr. Ed Johnson | PLACE OF TREATMENT | (C) Home Care |
| ADDRESS 123 2nd St., Columbia, S.C. (B) | | |
| DATES WORKED | SHIFTS/HOURS | CHARGE |
| 12/8/95 (D) | (E) 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)** Dates worked.
- (E)** Shift and/or hours worked.