

A SEPARATE CLAIM FORM MUST BE SUBMITTED FOR EACH PATIENT WHEN SENDING BILLS TO
Skaí Blue Cross Blue Shield

1. EMPLOYER NAME & DIVISION NUMBER _____		2. MEMBER ID NO. _____			
PATIENT'S INFORMATION	3. Patient's Last Name _____		Complete First Name _____ Initial _____		4. Date of Birth Mo. ____ Day ____ Yr. ____
	5. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	6. Patient's Relationship to Employee <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other (Specify) _____			
	7. Diagnosis or Nature of Illness or Injury _____ _____ _____				
	Date Illness Began: Mo. ____ Day ____ Yr. ____				
	8. Was this an accident? <input type="checkbox"/> Yes <input type="checkbox"/> No	9. If yes, date of accident. Mo. ____ Day ____ Yr. ____	10. Was this an automobile accident? <input type="checkbox"/> Yes <input type="checkbox"/> No	11. Was the illness/accident related to employment? <input type="checkbox"/> Yes <input type="checkbox"/> No	
EMPLOYEE INFORMATION	14. Employee Last Name _____		First Name _____ Initial _____		15. ASSIGNMENT: Payment for this claim should be made to: <input type="checkbox"/> Hospital <input type="checkbox"/> Doctor <input type="checkbox"/> Employee
	16. Employee Address _____				
	Street _____ City _____ State _____ Zip _____				
	I hereby authorize any insurance company, prepayment organization, employer, hospital, or physician, to release all information with respect to myself or any of my dependents which may have a bearing on the benefits payable under this or any other plan providing benefits or services. I certify that the above information in support of this claim is true and correct.				
OTHER INSURANCE	17. Do you have other health insurance with a <u>group</u> or <u>government program</u> ? <input type="checkbox"/> Yes (Please complete section below) <input type="checkbox"/> Yes, Medicare A (Please submit your "Explanation of Medicare Benefits" with these bills.) <input type="checkbox"/> No <input type="checkbox"/> Yes, Medicare B If Medicare, reason for coverage: <input type="checkbox"/> Over 65 <input type="checkbox"/> Disabled <input type="checkbox"/> Kidney Disease				
	18. Name of Insured _____		19. Name and Address of Insured's Employer _____		
	20. Name and address of other Insurance Company _____			21. Policy No. (other company) _____	
	22. Type of Coverage <input type="checkbox"/> Single <input type="checkbox"/> Family		Has other Insurance Company paid? <input type="checkbox"/> Yes If yes, please submit a copy of their payment with these bills. <input type="checkbox"/> No		

Date _____ Signature of Insured _____

GENERAL INFORMATION

You should submit your bills in a timely manner. To speed the processing of your claim, all bills must be itemized and attached to the claim form. ALL items on the claim form must be completed to insure proper payment.

NOTE: CANCELLED CHECKS, PAYMENT RECEIPTS, OR BALANCE FORWARD BILLS ARE NOT ACCEPTABLE.

HOW TO FILE A CLAIM

1. PREPARATION OF BILLS

A. Separate bills into the following groups:

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|----------------------|--------------------------------|--------------------|--------------------|-----------------------|
| 1. Physician's Bills | 3. Drug Bills or Prescriptions | 4. Durable Medical | 5. Ambulance Bills | 7. Physical Therapy & |
| 2. Hospital Bills | Drug Claim Forms | Equipment Bills | 6. Nurse's Bills | Speech Therapy Bills |
| | | | | 8. Other Bills |

B. Check the bills for the following information:

- | | |
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| <ol style="list-style-type: none">1. Physician's Bills - (Must be submitted on physician's Statement of Accounts or AMA approved uniform claim form showing physician's social security number or employer tax identification number.)<ol style="list-style-type: none">a. Full name of patientb. Date(s) of servicec. Full description of the type of procedures, medical services or supplies furnished for each dated. Amount charged for each servicee. Diagnosis2. Hospital Bills<ol style="list-style-type: none">a. Itemized statement from hospital, which must include diagnosis3. Drug Bills -<ol style="list-style-type: none">a. Full name of patientb. Date(s) of purchasec. Prescription numberd. Amount charged for each prescriptione. Name of drugs and diagnosis4. Durable Medical Equipment Bills - (Bill must include an invoice from the supplying firm.) NOTE: On purchase of equipment, you must receive prior approval to be eligible for payment.<ol style="list-style-type: none">a. Full name of patientb. Date(s) of servicesc. Description of itemsd. Charge for each iteme. Must have supporting statement from physician. | <ol style="list-style-type: none">5. Ambulance Bills - (Bills must be on ambulance firm's letterhead.)<ol style="list-style-type: none">a. Full name of patientb. Mileage of tripc. Charges per miled. Points of departure and mileagee. Description of other services (i.e., oxygen, equipment, etc.)f. Charge for each serviceg. Total amount charged6. Nurse's Bills - (Must have signature and registration or license number of R.N. or L.P.N.)<ol style="list-style-type: none">a. Full name of patientb. Professional status (i.e., R.N. or L.P.N., etc.) of each servicec. Beginning and ending dates of the nursing serviced. Time & number of hours workede. Charge for nursing servicef. Nurse's name7. Physical Therapy and Speech Therapy Bills - (Must be on therapist's stationery.)<ol style="list-style-type: none">a. Full name of patientb. Date(s) of servicec. Charge for each serviced. Name of licensed therapiste. Must have appropriate evaluation forms submitted with bills8. Other Bills - (Must include an invoice from the person or organization who provided the services.)<ol style="list-style-type: none">a. Name of the person or organization who provided the servicesb. Full name of patientc. Date the service was providedd. Description of servicese. Charge for each service |
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2. PREPARATION OF CLAIM FORM

A. Patient Information (things to remember)

1. Enter FULL name of patient; patient's date of birth (month, day and year), and be sure to check the relationship to block.

B. Employee Information (things to remember)

1. You must enter FULL first and last name, middle initial.
2. You must enter the correct and complete Member Identification number before this claim can be processed.
3. You must enter the correct and complete address for mailing of payment.