skai BlueCross BlueShield

An Independent Licensee of the Blue Cross and Blue Shield Association

P.O. Box 50
Little Rock, Arkansas 72203-1460

A SEPARATE CLAIM FORM MUST BE SUBMITTED FOR EACH PATIENT WHEN SENDING BILLS TO

Skai Blue Cross Blue Shield

1. GROUP NUMBER & NAME _____

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
☐ Male ☐ Female

6. Patient's Relationship to Employee
◯ Self ◯ Spouse ◯ Child ◯ Other (Specify)

7. Diagnosis or Nature of Illness or Injury

Date Illness Began: Mo. _____ Day _____ Yr. _____

8. Was this an accident?
☐ Yes ☐ No

9. If yes, date of accident.
Mo. _____ Day _____ Yr. _____

10. Was this an automobile accident?
☐ Yes ☐ No

11. Was the illness/accident related to employment?
☐ Yes ☐ No

12. Is patient a full time student?
☐ Yes ☐ No

13. If yes, what school?

EMPLOYEE INFORMATION

14. Employee Last Name | First Name | Initial

15. ASSIGNMENT:
Payment for this claim should be made to:
☐ Hospital ☐ Doctor ☐ 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 group or government program?
☐ Yes (Please complete section below)
☐ No
☐ Yes, Medicare A
☐ Yes, Medicare B
(Please submit your "Explanation of Medicare Benefits" with these bills.)
If Medicare, reason for coverage: ☐ Over 65 ☐ Disabled ☐ 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
☐ Single
☐ Family

Has other Insurance Company paid?
☐ Yes If yes, please submit a copy of their payment with these bills.
☐ 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:

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

   B. Check the bills for the following information:

   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.)
      a. Full name of patient
      b. Date(s) of service
      c. Full description of the type of procedures, medical services or supplies furnished for each date
      d. Amount charged for each service
      e. Diagnosis
   2. Hospital Bills
      a. Itemized statement from hospital, which must include diagnosis
   3. Drug Bills -
      a. Full name of patient
      b . Date(s) of purchase
      c. Prescription number
      d. Amount charged for each prescription
      e. Name of drugs and diagnosis
   4. 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.
      a. Full name of patient
      b. Date(s) of services
      c. Description of items
      d. Charge for each item
      e. Must have supporting statement from physician.
   5. Ambulance Bills - (Bills must be on ambulance firm's letterhead.)
      a. Full name of patient
      b. Mileage of trip
      c. Charges per mile
      d. Points of departure and mileage
      e. Description of other services (i.e., oxygen, equipment, etc.)
      f. Charge for each service
      g. Total amount charged
   6. Nurse's Bills - (Must have signature and registration or license number of R.N. or L.P.N.)
      a. Full name of patient
      b. Professional status (i.e., R.N. or L.P.N., etc.) of each service
      c. Beginning and ending dates of the nursing service
      d. Time & number of hours worked
      e. Charge for nursing service
      f. Nurse's name
   7. Physical Therapy and Speech Therapy Bills - (Must be on therapist's stationery.)
      a. Full name of patient
      b. Date(s) of service
      c. Charge for each service
      d. Name of licensed therapist
      e. Must have appropriate evaluation forms submitted with bills
   8. Other Bills - (Must include an invoice from the person or organization who provided the services.)
      a. Name of the person or organization who provided the services
      b. Full name of patient
      c. Date the service was provided
      d. Description of services
      e. Charge for each service

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.