

Attach Receipts Here

COMPREHENSIVE MAJOR MEDICAL CLAIM FORM



(see reverse side for instructions)

Please Mail To: P.O. BOX 890029, CAMP HILL, PA 17089-0029

1. SUBSCRIBER/PATIENT

SUBSCRIBER'S NAME (First, Middle, Last)		IDENTIFICATION NO.		GROUP NO.	
PRESENT ADDRESS - STREET <input type="checkbox"/> NEW ADDRESS		CITY		STATE ZIP CODE	
PATIENT'S NAME (First, Middle, Last)		RELATIONSHIP OF PATIENT TO SUBSCRIBER <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Handicapped dependent <input type="checkbox"/> Other		SEX <input type="checkbox"/> M <input type="checkbox"/> F	BIRTH DATE ____/____/____

2. OTHER INSURANCE

Does the PATIENT have additional health insurance benefits? <input type="checkbox"/> NO <input type="checkbox"/> YES If YES, complete the following:					
POLICYHOLDER'S NAME		BIRTH DATE ____/____/____	EMPLOYMENT STATUS OF POLICYHOLDER <input type="checkbox"/> Active <input type="checkbox"/> Disabled <input type="checkbox"/> Retired Effective Date of Employment Status: ____/____/____		
Relationship of Policyholder To Subscriber <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other _____		Other Insurance Carrier's Name	Identification No.	Effective Date ____/____/____	
TYPE(S) OF COVERAGE		<input type="checkbox"/> Hospitalization	<input type="checkbox"/> Medical/Surgical	<input type="checkbox"/> Dental	<input type="checkbox"/> Vision <input type="checkbox"/> Drug
		<input type="checkbox"/> Major Medical	<input type="checkbox"/> Other (specify) _____		
CONTRACT COVERS		<input type="checkbox"/> Policyholder Only	<input type="checkbox"/> Policyholder/Spouse	<input type="checkbox"/> Policyholder/Children	<input type="checkbox"/> Family

3. MEDICARE

Is the PATIENT entitled to benefits under MEDICARE HOSPITALIZATION Insurance (Part A)? <input type="checkbox"/> NO <input type="checkbox"/> YES Effective Date ____/____/____	
Does the PATIENT receive benefits under MEDICARE MEDICAL Insurance (Part B)? <input type="checkbox"/> NO <input type="checkbox"/> YES Effective Date ____/____/____	
If you answered YES to either of the above, give employment status of the SUBSCRIBER listed in Part "1." <input type="checkbox"/> Active <input type="checkbox"/> Retired <input type="checkbox"/> Disabled	
Give Health Insurance Number from Medicare ID Card _____	

4. PATIENT'S CONDITION

DESCRIBE CONDITIONS FOR WHICH YOU ARE REQUESTING BENEFITS AT THIS TIME:		
Type of injury or illness	Name of Doctor Treating Injury/Illness	Date of First Symptoms
A. _____	_____	____/____/____
B. _____	_____	____/____/____
(Attach additional information, if necessary)		
WERE EXPENSES DUE TO AN ACCIDENTAL INJURY? NO YES		
If YES, give date of accident ____/____/____		
Give type/place of accident Work Auto Other (specify) _____		
WERE SERVICES RELATED TO HOSPITALIZATION? NO YES		
If YES, give date of admission ____/____/____ Give date of discharge ____/____/____		

5. AUTHORIZATION

If services were incurred in a hospital, should we pay the hospital/facility directly? NO YES	
I certify that the information provided on this claim form is correct and complete, and that I am claiming benefits only for charges actually incurred by the patient named. I authorize any hospital, physician, or other provider who participated in the care and treatment of the patient to release to Blue Cross and Blue Shield all medical or other information requested for the processing of this claim. I hereby agree to reimburse Blue Cross and Blue Shield in full should this claim be incorrectly paid.	
SUBSCRIBER SIGNATURE _____	DATE (Area Code) HOME PHONE _____ (Area Code) WORK PHONE _____

INSTRUCTIONS:

1. PLEASE ATTACH ITEMIZED bills TO THIS claim form. Each bill should include the following information:
 - NAME, ADDRESS, AND TELEPHONE NUMBER (ON official bill head) OF THE PROVIDER RENDERING THE SERVICE OR SUPPLYING THE ITEM.
 - PATIENT'S full NAME
 - DESCRIPTION OF EACH SERVICE RENDERED OR ITEM SUPPLIED
 - DATE AND AMOUNT CHARGED FOR EACH SERVICE OR ITEM SUPPLIED
 - DIAGNOSIS OF AILMENT
2. WHEN SUBMITTING PHARMACY RECEIPTS, THE PRESCRIPTION NUMBER* MUST BE INCLUDED FOR EACH PRESCRIPTION DRUG.
3. PLEASE BE SURE THAT A PHYSICIAN'S MEDICAL CERTIFICATION ACCOMPANIES bills for:
 - PURCHASE OR RENTAL OF DURABLE MEDICAL EQUIPMENT
 - PRIVATE DUTY NURSING
4. WHEN SUBMITTING EXPENSES FOR MORE THAN ONE FAMILY MEMBER, PLEASE USE A SEPARATE CLAIM FORM FOR EACH PERSON.
5. PLEASE COMPLETE THE CLAIM FORM CAREFULLY, AND BE SURE TO INCLUDE THE INFORMATION REQUESTED ABOVE. THIS WILL HELP TO AVOID UNNECESSARY DELAYS IN PROCESSING YOUR CLAIM.
6. IF YOU HAVE QUESTIONS REGARDING THE COMPLETION OF THIS CLAIM FORM, PLEASE CONTACT THE COMPREHENSIVE MAJOR MEDICAL SERVICE UNIT AT 215-567-3530 OR 1-800-562-7981 (OUTSIDE OF PHILADELPHIA COUNTY).

*PRESCRIPTION DRUGS IS AN OPTIONAL BENEFIT UNDER YOUR COMPREHENSIVE MAJOR MEDICAL PROGRAM. CHECK WITH YOUR EMPLOYER TO SEE IF THIS BENEFIT IS AVAILABLE TO YOU.