

1

Employee's

Name _____

Identification

Number _____
(Please include the letters if included on your ID card)

FOR OFFICE USE ONLY

HEALTH BENEFITS CLAIM FORM



South Carolina

BlueCross BlueShield of South Carolina is an independent licensee of the Blue Cross Blue Shield Association.

Columbia Service Center
P.O. Box 100300
Columbia, SC 29202-3121

2

Patient's

Name _____
First Middle Initial Last

3

The Patient is: Female Male
And is the: Employee Employee's Spouse Employee's Child

4

Patient's Date of Birth _____
Month Day Year

5

Employee's Mailing Address _____
 Check if new 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 Part A? Yes No
Or by Medicare Part B? Yes No
If yes, please attach your Explanation of Medicare Benefits (EOMB). It is necessary to process this claim.
Medicare Health Insurance Benefit Number: _____

9

Is the patient covered under any other health benefit plan? Yes No
If yes, please attach your Explanation of Benefits (EOB) from the other insurance company. Also, please complete this entire section as it is necessary to process this claim.
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 with the required information needed to process your claim.

- A - Physician name, Tax ID# (TIN) and address.
- B - Full name of patient should appear on every bill, not just name of person paying bill.
- C - The date of medical treatment.
- D - Procedure code(s) for type of medical treatment.
- E - Diagnosis (ICD) code.
- F - Separate cost for each treatment.

PHYSICIANS BILLS

A Harry Smith, M.D. (123-45-6789) Columbia, S.C.	
Patient John Jones B	C 9/18/95 - 9/23-75
D Surgery, Appendectomy Procedure (CPT) code: 44960	F 250.00 No Charge No Charge 15.00 5.00
Please provide	

MEDICAL EQUIPMENT BILLS

ACE BRACE Co. Columbia, S.C.	
A Patient Nancy Smith	C Date 9/17/95
A Address 2905 Start Rd.	A Phone 788-1234
B Dr. Jones	D Diabetes - 250.92
Quantity	Medical Equipment Purchased
1	E Wheelchair - Economy
	F Code: E113
	Tax
	11.96
	310.96

Note: A letter of medical necessity is required for medical equipment purchase(s) before major medical will process.

- A - Full name of patient, address and telephone #.
- B - Name of doctor ordering medical equipment.
- C - Date medical equipment purchased.
- D - Diagnosis code(s).
- E - Description of equipment purchased.
- F - Procedure code(s) of equipment purchased.

PHARMACIST BILLS

PRICE PHARMACY 200 Market Street Columbia, S.C.	
A Mary G. Jones	B Hypertension - 401.9
Date	Prescription Number Description
C 8/31/95	D 575-516 60 Aldoril25mg Dr. G.S. Smith
	588-152 60 HCTZ50mg Dr. G.S. Smith
10/1/95	592-321 30 Aldoril25mg Dr. G.S. Smith
12/9/95	599-472 60 Aldoril25mg Dr. G.S. Smith
F G.S. Smith	Charge
	E 11.60
	7.25
	6.20
	11.60
	36.65

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

NURSING BILLS

A Diane Smith RN	A LICENSE OR REGISTRY NO. 12345
B Mr. Ed Johnson	C PLACE OF TREATMENT Home Care
B 123 2nd St., Columbia, S.C.	D Stroke - 250.92
ADDRESS	CHARGE
DATES WORKED	SHIFT/HOURS
E 12/8/95	F 7-3 p.m./8 hrs.
12/9/95	7-3 p.m./8 hrs.
12/10/95	11-7 a.m./8 hrs.
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 - Diagnosis code(s).
- E - Dates worked.
- F - Shift and/or hours worked.

On any of the above forms, please provide proof of payment if patient has paid.

Non-Discrimination Statement and Foreign Language Access

We do not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation or health status in our health plans, when we enroll members or provide benefits.

If you or someone you're assisting is disabled and needs interpretation assistance, help is available at the contact number posted on our website or listed in the materials included with this notice (TDD: 711).

Free language interpretation support is available for those who cannot read or speak English by calling one of the appropriate numbers listed below.

If you think we have not provided these services or have discriminated in any way, you can file a grievance by emailing contact@hcrcompliance.com or by calling our Compliance area at 1-800-832-9686 or the U.S. Department of Health and Human Services, Office for Civil Rights at 1-800-368-1019 or 1-800-537-7697 (TDD).

Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de este plan de salud, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-844-396-0183. (Spanish)

如果您，或是您正在協助的對象，有關於本健康計畫方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥 1-844-396-0188。(Chinese)

Nếu quý vị, hoặc là người mà quý vị đang giúp đỡ, có những câu hỏi quan tâm về chương trình sức khỏe này, quý vị sẽ được giúp đỡ với các thông tin bằng ngôn ngữ của quý vị miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-844-389-4838 (Vietnamese)

이 건강보험에 관하여 궁금한 사항 혹은 질문이 있으시면 1-844-396-0187로 연락해 주십시오. 귀하의 비용 부담없이 한국어로 도와드립니다. (Korean)

Kung ikaw, o ang iyong tinutulungan, ay may mga katanungan tungkol sa planong pangkalusugang ito, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika nang walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-844-389-4839. (Tagalog)

Если у Вас или лица, которому вы помогаете, имеются вопросы по поводу Вашего плана медицинского обслуживания, то Вы имеете право на бесплатное получение помощи и информации на русском языке. Для разговора с переводчиком позвоните по телефону 1-844-389-4840. (Russian)

إن كان لديك أو لدى شخص تساعد أسئلة بخصوص خطة الصحة هذه، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون أية تكلفة. للتحدث مع مترجم اتصل ب 1-844-396-0189 (Arabic)

Si ou menm oswa yon moun w ap ede gen kesyon konsènan plan sante sa a, se dwa w pou resevwa asistans ak enfòmasyon nan lang ou pale a, san ou pa gen pou peye pou sa. Pou pale avèk yon entèprèt, rele nan 1-844-398-6232. (French/Haitian Creole)

Si vous, ou quelqu'un que vous êtes en train d'aider, avez des questions à propos de ce plan médical, vous avez le droit d'obtenir gratuitement de l'aide et des informations dans votre langue. Pour parler à un interprète, appelez le 1-844-396-0190. (French)

Jeśli Ty lub osoba, której pomagasz, macie pytania odnośnie planu ubezpieczenia zdrowotnego, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer 1-844-396-0186. (Polish)

Se você, ou alguém a quem você está ajudando, tem perguntas sobre este plano de saúde, você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para falar com um intérprete, ligue para 1-844-396-0182. (Portuguese)

Se tu o qualcuno che stai aiutando avete domande su questo piano sanitario, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare 1-844-396-0184. (Italian)

あなた、またはあなたがお世話をされている方が、この健康保険についてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、1-844-396-0185 までお電話ください。 (Japanese)

Falls Sie oder jemand, dem Sie helfen, Fragen zu diesem Krankenversicherungsplan haben bzw. hat, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-844-396-0191 an. (German)

اگر شما یا فردی که به او کمک می کنید سؤالاتی درباره ی این برنامه ی بهداشتی داشته باشید، حق این را دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت کنید. برای صحبت کردن با مترجم، لطفاً با شماره ی 1-844-398-6233 تماس حاصل نمایید. (Persian-Farsi)

Ni da doodago t'áá háida bíká'aná nílwo'ígíí díí Béeso Ách'ááh naa'nilígi háá'ída yí na' ídíł kidgo, nihá'áhóót'i' nihí ká'a'doo wołgo kwii ha'át'ishíí bí na'ídołkidígi doo bik'é'azláagóó. Ata' halne'é ła' bich'í' ha desdizih nínízingo, koji' béesh bee hólne' 1-844-516-6328. (Navajo)

Vann du adda ebbah es du am helfa bisht, enniichi questions hend veyyich *deah health plan*, hend diah's recht fa hilf un information greeya in eiyah aykni shprohch unni kosht. Fa shvetza mitt en interpreter, roof deah nummah oh 1-833-584-1829. (Pennsylvania Dutch)