BlueCross BlueShield of Illinois

P.O. Box 660603 • Dallas, TX 75266-0603

# Claim Form
## to Pay Insured/Subscriber

**Each item on this form needs to be completed.**
**Instructions for completion are listed on the reverse side.**

Please print or type.

**1**

**Insured/Subscriber Name** (Last, First, Middle Initial)

**Mailing Address**

**City and State** | **ZIP Code**

**Insured Employed?** Date of Retirement: Month Day Year

☐ Yes ☐ No ☐ Retired _____/_____/_____

**2**

**Group Number** | **Insured/Subscriber Identification Number** (from ID card)

**Patient's Full Name** (Last, First, Middle)

**Patient's Sex** | **Patient's Date of Birth** Month Day Year _____/_____/_____

**Patient's Relationship to Insured**

☐ Self ☐ Spouse ☐ Child ☐ Other (explain) _____

**3**

**Type of treatment received:**
Check only one type and attach itemized statements. Please use a separate claim form for each different type of treatment.

**Please note:** Preventive care includes immunizations, routine well baby care, routine physical examinations, vision and hearing exams.

Month Day Year

☐ Injury — Date of accident: _____/_____/_____

☐ Illness — Date of first symptom: _____/_____/_____

☐ Pregnancy — Date of conception: _____/_____/_____

☐ Preventive — Date of service: _____/_____/_____

**4**

**Describe: Diagnosis, symptoms of illness or injury or explain preventive or routine care received.**

_____

_____

_____

**5**

**Was illness or injury work connected?** ☐ Yes ☐ No

**Name and address of employer**

_____

_____

**6**

**If injury, was a motor vehicle involved?** ☐ Yes ☐ No

**7**

**Is patient covered under any other health benefits plan (besides Medicaid, Medicare or CHAMPUS)?** ☐ Yes ☐ No

Insurance Co. _____

Address _____ Effective date of coverage Month Day Year _____/_____/_____

Employer _____ Sex of Insured ☐ Male ☐ Female

Insured name _____ Date of birth of insured _____/_____/_____

Policy # _____ Relationship to patient _____

**If the other coverage is primary, attach the other insurance company's Explanation of Benefits.**

**8**

**Medicare — Is the patient:** Month Day Year

a) Entitled to benefits under Medicare insurance (Part A)? ☐ Yes ☐ No Effective _____/_____/_____

b) Entitled to benefits under Medicare insurance (Part B)? ☐ Yes ☐ No Effective _____/_____/_____

c) Entitled to benefits under Medicare due to a disability? ☐ Yes ☐ No Effective _____/_____/_____

Patient's Medicare Identification Number. (From Medicare ID card) _____

**9**

I certify the above is complete and correct and that I am claiming benefits only for charges incurred by the patient named above. Authorization is hereby given to any Hospital, Physician, Dentist, Provider, Insurance Carrier or other entity to give Blue Cross and Blue Shield of Illinois, upon request, any medical information. Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

| **Signature of Insured** | **Date** | **Daytime telephone number** |
|---|---|---|
| | | |

**10**

| Total amount for ALL covered services and supplies received. | **$** |
|---|---|

**Itemized Bill(s) for covered services and supplies must be attached.** ***(See Instructions on reverse side.)***

BlueCross BlueShield of Illinois

# Claim Form
## to Pay Insured/Subscriber

## INSTRUCTIONS

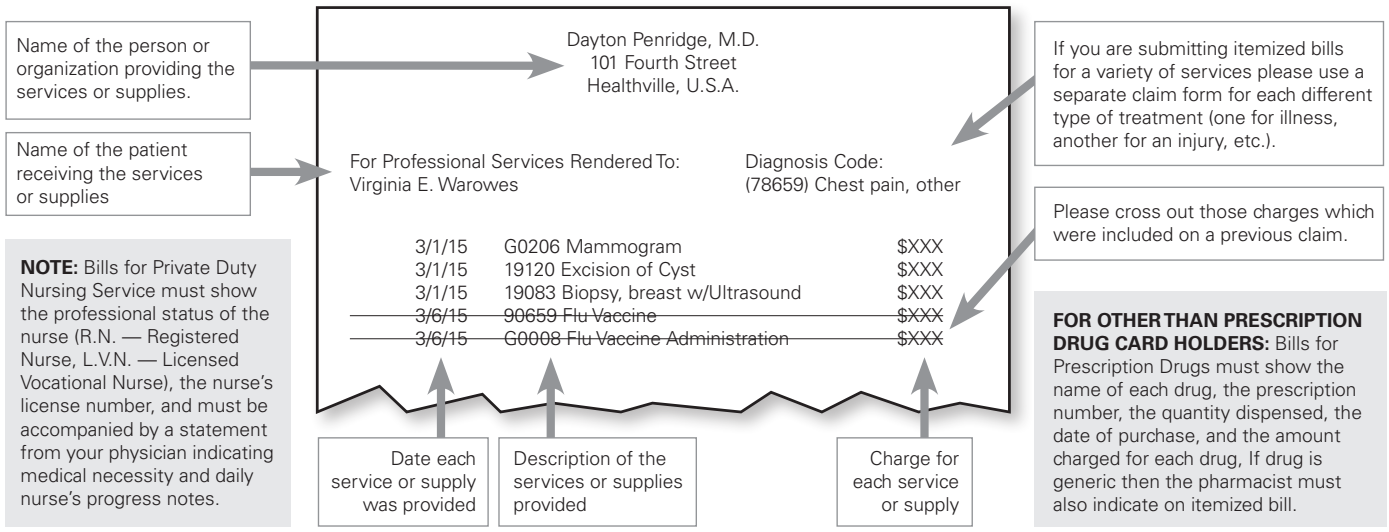
**Important: DO NOT file this form if your Provider of Service is submitting these charges to Blue Cross and Blue Shield of Illinois.**

**Please complete every item on claim form.**

| | | |
|---|---|---|
| **1** | Insured/subscriber's name, address and employment status | Please show the insured/subscriber's name exactly as it appears on the Blue Cross and Blue Shield of Illinois identification card and specify the current address including the ZIP code. Check appropriate box indicating the insured/subscriber's employment status. If retired, give date of retirement. |
| **2** | Patient information | Make sure the group number and identification number are exactly as shown on the insured's identification card. List patient's full name; no nicknames or initials. Check the appropriate blocks for the patient's sex and relationship to the insured. Ensure the patient's correct date of birth is shown. |
| **3** | Type of treatment received | Check only one treatment type (injury, illness, pregnancy or preventive care) and specify date of injury, date of first symptom, date of conception or date preventive care was received. You may attach multiple itemized statements if they are for one type of treatment (example: illness only, preventive care only). |
| **4** | Diagnosis or symptoms of illness or injury | Give diagnosis or a brief description of symptoms. If preventive care services were received, state the type of care (routine physical, hearing exam, vision exam, immunization or diagnosis, etc.). |
| **5** | If illness or injury is in any way work-related | Check appropriate box and enter name and address of employer. |
| **6** | If motor vehicle injury | Check appropriate box. |
| **7** | Other insurance | Please check appropriate box. If "yes," complete the required information. |
| **8** | Medicare information | Please check appropriate box concerning Medicare eligibility. If "yes," show effective date and give Medicare identification number.<br>Medicare Enrollees should include a copy(s) of the Medicare Explanation of Benefits Form(s) (EOB) with their itemized statements unless patient is actively employed and requires group coverage to pay primary. |
| **9** | Insured's signature, date and daytime telephone number | Please sign and date this form and attach your physician's itemized letterhead statement(s). The itemized statement(s) should contain all the information shown in the following example: |

**10**

**<u>Example of Itemized Bill</u> — Please remember to attach the original bill(s) to the claim form and make a copy for your records. <u>Itemized bills cannot be returned.</u>**




**NOTE:** Bills for Private Duty Nursing Service must show the professional status of the nurse (R.N. — Registered Nurse, L.V.N. — Licensed Vocational Nurse), the nurse's license number, and must be accompanied by a statement from your physician indicating medical necessity and daily nurse's progress notes.

**FOR OTHER THAN PRESCRIPTION DRUG CARD HOLDERS:** Bills for Prescription Drugs must show the name of each drug, the prescription number, the quantity dispensed, the date of purchase, and the amount charged for each drug, If drug is generic then the pharmacist must also indicate on itemized bill.

This completed form, together with the itemized bills, should be submitted to:

Blue Cross and Blue Shield of Illinois
P.O. Box 660603
Dallas, Texas 75266-0603