



**BlueCross of Northeastern Pennsylvania
Pennsylvania BlueShield**

Independent Licensees of the Blue Cross and Blue Shield Association
Registered Marks of the Blue Cross and Blue Shield Association

MAJOR MEDICAL CLAIM STATEMENT

SUBSCRIBER NAME (LAST, FIRST, M.I.)			SUBSCRIBER ID NUMBER	
PRESENT STREET ADDRESS			CITY	
STATE	ZIP CODE	HOME PHONE ()	WORK PHONE ()	PLAN CODE
IS THIS A CHANGE OF ADDRESS? <input type="checkbox"/> YES <input type="checkbox"/> NO	EMPLOYER NAME			GROUP NUMBER
PATIENT NAME		DATE OF BIRTH	SEX <input type="checkbox"/> M <input type="checkbox"/> F	RELATIONSHIP TO SUBSCRIBER <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD
If you have a Blue Shield Plan C, 1800S, or 5000S agreement, please indicate the annual income for yourself and all dependents for the calendar year: <input type="checkbox"/> Under \$6,000 <input type="checkbox"/> \$6,000 - \$11,999 <input type="checkbox"/> \$12,000 - \$17,999 <input type="checkbox"/> \$18,000 - \$23,999 <input type="checkbox"/> \$24,000 - \$35,999 <input type="checkbox"/> \$36,000 and over				
SPOUSE'S SOCIAL SECURITY NUMBER		SPOUSE'S NAME		
IF PATIENT IS OVER 19 YEARS OF AGE, CHECK STATUS AT TIME EXPENSES INCURRED: <input type="checkbox"/> FULL TIME STUDENT (SCHOOL NAME): _____ <input type="checkbox"/> TOTALLY HANDICAPPED (NATURE OF DISABILITY): _____				
TYPE OF ILLNESS/INJURY FOR WHICH YOU ARE REQUESTING BENEFITS:			DATE FIRST TREATED: ____/____/____	
NAME, DEGREE, ADDRESS OF DOCTOR TREATING ILLNESS:				
ARE EXPENSES DUE TO AN ACCIDENTAL INJURY? <input type="checkbox"/> YES <input type="checkbox"/> NO		IF ACCIDENT RELATED, WHAT WAS DATE OF ACCIDENT? ____/____/____		
TYPE OF ACCIDENT: <input type="checkbox"/> WORK <input type="checkbox"/> HOME <input type="checkbox"/> AUTO <input type="checkbox"/> MOTORCYCLE <input type="checkbox"/> SCHOOL <input type="checkbox"/> OTHER				
BRIEF DESCRIPTION OF ACCIDENT: _____				
HAS/WILL CLAIM BE FILED UNDER ANY WORKER'S COMPENSATION ACT?		<input type="checkbox"/> YES <input type="checkbox"/> NO		
HAS/WILL CLAIM BE FILED AGAINST ANY PERSON(S) OR ENTITY LIABLE FOR THE INJURY?		<input type="checkbox"/> YES (Name) _____ <input type="checkbox"/> NO		
IS PATIENT ENTITLED TO BENEFITS UNDER:				
MEDICARE HOSPITAL INSURANCE (PART A):		<input type="checkbox"/> YES <input type="checkbox"/> NO EFFECTIVE DATE OF COVERAGE: ____/____/____		
MEDICARE MEDICAL INSURANCE (PART B):		<input type="checkbox"/> YES <input type="checkbox"/> NO EFFECTIVE DATE OF COVERAGE: ____/____/____		
ENTER PATIENT'S HEALTH INSURANCE NUMBER FROM THE MEDICARE ID CARD: _____				
IS THE PATIENT COVERED UNDER ANY OTHER HEALTH INSURANCE POLICY?		<input type="checkbox"/> YES <input type="checkbox"/> NO		
IF YES, WHAT IS THE EFFECTIVE DATE OF COVERAGE? ____/____/____				
EMPLOYER NAME: _____		INSURANCE COMPANY NAME: _____		
INSURED'S NAME: _____		DATE OF BIRTH: ____/____/____		
POLICY NUMBER: _____				
TYPE OF COVERAGE: <input type="checkbox"/> HOSPITAL <input type="checkbox"/> MEDICAL/SURGICAL <input type="checkbox"/> MAJOR MEDICAL <input type="checkbox"/> DRUG <input type="checkbox"/> DENTAL <input type="checkbox"/> VISION <input type="checkbox"/> OTHER (SPECIFY): _____				
I hereby authorize any person or organization furnishing services or supplies, or who participates in the care and treatment of the patient to release to the Blue Cross and Blue Shield Plans all medical or other information requested for the adjudication of this claim. Further, I authorize the Social Security Administration to furnish to Blue Cross and Blue Shield medical or other information acquired by it under Title XVIII of the Social Security Act (Medicare) to the extent necessary to process any claim under my agreement. Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. I certify that the information given by me in support of this claim is true and correct. I recognize that (1) I must repay any amounts received as a result of any misrepresentation, and that (2) Blue Cross and Blue Shield reserve the right at their sole discretion to cancel any policy upon which any amounts have been claimed or paid as a result of any misrepresentation.				
Subscriber's Signature _____				Date _____

PLEASE READ THIS FIRST INSTRUCTIONS FOR FILING MAJOR MEDICAL CLAIMS

1. For full details and a description of various types of expenses covered, please read your Blue Cross and Blue Shield benefits booklet or agreement.

For non-group (direct pay) subscribers enrolled in Medicare, claims must be submitted to Medicare prior to submitting any claims to Blue Cross, Blue Shield, and Major Medical.

For group subscribers enrolled in Medicare, please contact your group benefits administrator to determine if Medicare is the primary payer.

2. Please file your Major Medical claims with us throughout the year to avoid a year end payment delay. To avoid delays in handling your claims, be sure your answers to all questions on the claim form are complete and correct. Please submit your claims according to the time frame specified in your benefits booklet or agreement.
3. Separate all bills for each family member. A separate claim form is needed for each person on your contract. Additional claim forms may be obtained from the Blue Cross and Blue Shield office nearest you.
4. Bills must include:
 - name and address (on letterhead stationary) of provider of service or supplier;
 - patient's full name;
 - description of service or supply (doctor's office visits, nursing service, etc.); and
 - amount charged for each service or supply.

The following are not acceptable: Receipts that show only a balance due, receipts that show payments were received on a balance, cash register receipts, cancelled checks, money order receipts, and personal listings. Since we keep the bills, receipts, and forms you send us, please make copies for your records.

5. **Note:** Remove all staples to avoid a delay in the processing of your claim.
6. Bills for the following services should have this additional information:

Private Duty Nurse: A doctor's statement of medical necessity and the specific dates of nursing services must accompany each claim statement. The bill must list the nurse's registration, license number, and shifts worked.

Oxygen or Durable Medical Equipment (wheelchair, respirator, etc): A doctor's note of medical necessity for such equipment must accompany the claim statement. If you are renting equipment, have the supplier note the purchase price of the equipment and the length of time it will be used.

7. When sending bills, please circle only the services or supplies you are claiming.
Note: Please include all payment and/or rejection notices from Blue Cross, Blue Shield, Medicare, 65-Special, or any type of commercial insurance. These notices are usually called "Summaries" or "Explanations of Benefits."
8. Mail all itemized bills and any information requested with the claim form to:

**BLUE CROSS OF NORTHEASTERN PENNSYLVANIA
MAJOR MEDICAL DEPARTMENT
PO BOX 3100
WILKES-BARRE PA 18773**

9. Be sure you have included the requested information, so we are able to process your claim promptly.