1 **Employee's** Name _____

Identification Number _____

(Please include the letters if included on your ID Card)

FOR OFFICE USE ONLY

2 **Patient's** Name _____

First Middle Initial Last

HEALTH BENEFITS CLAIM FORM

BlueCross BlueShield of Kansas City

An Independent Licensee of the Blue Cross and Blue Shield Association.

Columbia Service Center
P.O. Box 100121
Columbia, SC 29202-3121

www.MyInsuranceManager.com/KC

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 Health Insurance, Part A? ☐ Yes ☐ No

Or by Supplemental Medical Insurance, Part B? ☐ Yes ☐ No

If yes, please attach your "Explanation of Medicare Benefits." It is necessary to process this claim.

Complete the following 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" 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

MEDICAL AND SURGICAL BILLS
SHOULD INCLUDE THE FOLLOWING:

Ⓐ Physician name and address.

Ⓑ Full name of patient should appear on every bill, not just name of person paying bill.

Ⓒ The date of surgery or medical treatment.

Ⓓ The type of surgery performed or type of medical treatment.

Ⓔ Separate cost for each treatment.

Harry Smith, M.D. (Ⓐ)
Columbia, S.C.

Patient
John Jones (Ⓑ)

	(Ⓓ)	(Ⓔ)
(Ⓒ) 9/18/95	Surgery, Appendectomy	250.00
9/17 - 23/95	Hospital Calls (Ⓓ)	No Charge
(Ⓒ) 10/23/95	(Ⓓ) Office Call	No Charge
12/1/95	Office Call–Virus (Ⓓ)	15.00
	Injection	5.00

MEDICAL EQUIPMENT
SHOULD INCLUDE THE FOLLOWING:

ACE BRACE Co. (Ⓐ)
Columbia, S.C.

Patient Nancy Smith (Ⓒ) **Date** 9/17/95

Address 2905 Start Rd. **Phone** 788-1234

Dr. Jones (Ⓑ)

Quantity	Rx	Price
1	Wheelchair - Economy (Ⓓ)	299.00
	TAX	11.96
		310.96

Ⓐ Full name of patient.

Ⓑ Name of Doctor ordering Medical Equipment.

Ⓒ Date Medical Equipment purchased.

Ⓓ Description of equipment purchased.

Note: Letter of medical necessity is required before major medical will process.

DRUGGIST BILLS*
SHOULD INCLUDE THE FOLLOWING:

Ⓐ Full name of patient. (Separate bill should be submitted for each member of family for whom major medical expense benefits are being claimed.)

Ⓑ Date of purchase.

Ⓒ Prescription number, quantity, name and strength of drug.

Ⓓ Separate charge for each prescription.

Ⓔ Pharmacist's signature.

PRICE PHARMACY
200 Market Street
Columbia, S.C.

Patient:
(Ⓐ) Mary G. Jones

Date	Prescription Number Description	Charge
(Ⓑ) 8/31/95	(Ⓒ) 575-516 60 Aldoril25mg Dr. G.S. Smith	(Ⓓ) 11.60
	588-152 60 HCTZ50mg Dr. G.S. Smith	7.25
10/1/95	592-321 30 Aldoril25mg Dr. G.S. Smith	6.20
12/9/95	599-472 60 Aldoril25mg Dr. G.S. Smith	11.60
(Ⓔ)		36.65

NURSING BILLS
SHOULD INCLUDE THE FOLLOWING:

(Ⓐ) **NURSE** Diane Smith RN

LICENSE OR REGISTRY NO. (Ⓐ) 12345

(Ⓑ) **FOR** Mr. Ed Johnson

PLACE OF TREATMENT (Ⓒ) Home Care

(Ⓑ) **ADDRESS** 123 2nd St., Columbia, S.C.

DATES WORKED	SHIFTS/HOURS	CHARGE
12/8/95 (Ⓓ)	(Ⓔ) 7-3 p.m./8 hrs.	
12/9/95	7-3 p.m./8 hrs.	40.00
12/10/95	11-7 a.m./8 hrs	40.00
TOTAL HOURS	24 hrs.	

Ⓐ Nursing bills must clearly indicate whether the nurse is a Registered Nurse (RN) or Licensed Practical Nurse (LPN). Also the license or Registry Number.

Ⓑ Name and address of patient.

Ⓒ Were nursing services provided in Hospital, Home or Elsewhere?

Ⓓ Dates worked.

Ⓔ Shift and/or hours worked.

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.

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 online at 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，請撥電話 [在此插入數字 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 đở 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 건보험에 관하여 궁금한 사항 혹은 질문이 있으시면 1-844-396-0187 로 연락주십시오. 귀하의 비용 부담없이 한국어로 도와드립니다. PC 명조 (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 تساعده أسئلة بخصوص خطة الصحة هذه، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية 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, a des questions à propos de ce plan médical, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 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 در باره‌ی این برنامه‌ی 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 شماره‌ی 1-844-398-6233 تماس حاصل نمایید. (Persian-Farsi)
