FOR OFFICE USE ONLY

HEALTH BENEFITS CLAIM FORM

BlueCross BlueShield of North Carolina

Blue Cross and Blue Shield of North Carolina is an independent licensee of the Blue Cross and Blue Shield Association.

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

MyHealthToolkitNC.com

1 **Employee's** Name _____

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

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 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 _____

10 CERTIFICATION OF MEMBER

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:

- (A) Physician name and address.
- (B) Full name of patient should appear on every bill, not just name of person paying bill.
- (C) The date of surgery or medical treatment.
- (D) The type of surgery performed or type of medical treatment.
- (E) Separate cost for each treatment.

Harry Smith, M.D. (A)
Columbia, S.C.

Patient
John Jones (B)

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

MEDICAL EQUIPMENT
SHOULD INCLUDE THE FOLLOWING:

ACE BRACE Co. (A)
Columbia, S.C.

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

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

Dr. Jones (B)

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

- (A) Full name of patient.
- (B) Name of Doctor ordering Medical Equipment.
- (C) Date Medical Equipment purchased.
- (D) Description of equipment purchased.

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

DRUGGIST BILLS*
SHOULD INCLUDE THE FOLLOWING:

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

PRICE PHARMACY
200 Market Street
Columbia, S.C.

Patient:
(A) Mary G. Jones

Date (B)	Prescription Number (C) Description	Charge (D)
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
(E)		36.65

NURSING BILLS
SHOULD INCLUDE THE FOLLOWING:

(A) **NURSE** Diane Smith RN

LICENSE OR REGISTRY NO. (A) 12345

(B) **FOR** Mr. Ed Johnson

PLACE OF TREATMENT (C) Home Care

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

DATES WORKED (D)	SHIFTS/HOURS (E)	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.	

- (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) Dates worked.
- (E) Shift and/or hours worked.