



Health Advantage

An Independent Licensee of the Blue Cross and Blue Shield Association

P.O. Box 8069
Little Rock, Arkansas 72203-8069

CLAIM FORM

A SEPARATE CLAIM FORM MUST BE SUBMITTED FOR EACH PATIENT
WHEN SENDING BILLS TO HEALTH ADVANTAGE

Please refer to the instructions on back of this form when filing your claims.

HEALTH ADVANTAGE
IDENTIFICATION NUMBER _____ GROUP NUMBER _____
(as indicated on your identification card including the three-digit prefix)

PATIENT'S INFORMATION	Patient's Last Name		Complete First Name		Initial	Date of Birth		
	Sex		Patient's Relationship to Policyholder					Mo. ____ Day ____ Yr. ____
	<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other (Specify)					
	Description of illness or injury requiring treatment.						Date Illness Began: Mo. ____ Day ____ Yr. ____	
	Was this an accident?		If yes, date of accident		Was this an automobile accident?		Was the illness/accident related to employment?	
<input type="checkbox"/> Yes <input type="checkbox"/> No		Mo. ____ Day ____ Yr. ____		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No		
Is patient a full time student?		If yes, what school?						
<input type="checkbox"/> Yes <input type="checkbox"/> No								

OTHER INSURANCE	THIS PART MUST BE COMPLETED IN FULL BEFORE WE CAN DETERMINE RESPONSIBILITIES FOR YOUR CLAIM.						
	Do you have Medicare?						
	Part A: <input type="checkbox"/> No <input type="checkbox"/> Yes; Effective Date _____				If yes, please file the claim with Medicare first. Then submit a copy of your Explanation of Medicare Benefits with this form.		
	Part B: <input type="checkbox"/> No <input type="checkbox"/> Yes; Effective Date _____						
	Is the patient covered by other medical insurance? If yes, and the policy is with a group (such as through an employer), please complete the following section.						
	<input type="checkbox"/> No <input type="checkbox"/> Yes						
Name of insured policyholder:			Name and address of insured's employer:				
Name and Address of other insurance company:					Policy Number (other insurance co.)		
Type of Coverage:		Has the other insurance company paid?					
<input type="checkbox"/> Single		<input type="checkbox"/> Yes					
<input type="checkbox"/> Family		<input type="checkbox"/> No					
If yes, please submit a copy of their payment information with this form.							

POLICYHOLDER'S INFORMATION	Policyholder's Last Name		First Name	Initial	Policyholder's Employer	
	Policyholder's Address					
	Street		City		State	Zip
	I certify the above is complete and correct and that I am claiming benefits for charges incurred by the above named patient.					
Policyholder's Signature _____				Date _____		

IF YOU HAVE ANY QUESTIONS, PLEASE CONTACT CUSTOMER SERVICE AT 800-843-1329.

GENERAL INFORMATION

You should submit your bills in a timely manner. To speed the processing of your claim, all bills must be itemized and attached to the claim form. ALL items on the claim form must be completed to insure proper payment.

NOTE: CANCELLED CHECKS, PAYMENT RECEIPTS, OR BALANCE FORWARD BILLS ARE NOT ACCEPTABLE

HOW TO FILE A CLAIM

1. PREPARATION OF BILLS

A. Separate bills into the following groups:

- | | | | |
|-------------------------------------------------------|-----------------------------------------------|--------------------|--------------------|
| 1. Physician's Bills | 3. Nurse's Bills | 5. Ambulance Bills | 7. Durable Medical |
| 2. Drug Bills or Blue Cross
Pharmacist's Statement | 4. Physical Therapy &
Speech Therapy Bills | 6. Hospital Bills | Equipment Bills |
| | | | 8. Other Bills |

B. Check the bills for the following information:

1. Physician's Bills - (Must be submitted on physician's office bill or a Blue Shield claim form.)
 - a. Full name of patient
 - b. Date(s) of service
 - c. Full description of the type of procedures, medical services or supplies furnished for each date.
 - d. Amount charged for each service
 - e. Diagnosis
2. Drug Bills or Health Advantage Pharmacist's Statement - (Must be submitted on official pharmacy invoice or stationery)
 - a. Full name of patient
 - b. Date(s) of purchase
 - c. Prescription number
 - d. Amount charged for each prescription
 - e. Name of drug
3. Nurse's Bills - (Must have registration or license number of R.N. or L.P.N.)
 - a. Full name of patient
 - b. Professional status (i.e., R.N., or L.P.N., etc.) of each service
 - c. Beginning and ending dates of the nursing service
 - d. Time & number of hours worked
 - e. Charge for the nursing service
 - f. Nurse's name
4. Physical Therapy and Speech Therapy Bills - (Must be on therapist's stationery)
 - a. Full name of patient
 - b. Date(s) of service
 - c. Charge for each service
 - d. Name of licensed therapist
5. Ambulance Bills (Bills must be on ambulance firm's letterhead)
 - a. Full name of patient
 - b. Mileage of trip
 - c. Charges per mile
 - d. Points of departure and mileage
 - e. Description of other services (i.e., oxygen, equipment, etc.)
 - f. Charge for each service
 - g. Total amount charged
6. Hospital Bills
 - a. Itemized statement from hospital, which must include diagnosis
7. Durable Medical Equipment Bills - (Bill must include an invoice from the supplying firm) NOTE: On purchase of equipment, you must receive prior approval from Arkansas Blue Cross and Blue Shield to be eligible for payment
 - a. Full name of patient
 - b. Date(s) of services
 - c. Description of items
 - d. Charge for each item
 - e. Must have supporting statement from physician.
8. Other Bills - (Must include an invoice from the person or organization who provided the services)
 - a. Name of person or organization who provided the services
 - b. Full name of patient
 - c. Date the service was provided
 - d. Description of services
 - e. Charge for each service

NOTE:

DO NOT USE THIS FORM TO FILE CHARGES WHICH ARE BEING FILED FOR YOU BY THE HOSPITAL AND/OR PHYSICIAN. PLEASE CHECK WITH THE HOSPITAL AND/OR PHYSICIAN (OR OTHER PROVIDERS OF CARE) BEFORE FILING THE CLAIM YOURSELF.

2. PREPARATION OF CLAIM FORM

A. Patient information (things to remember)

1. Enter FULL name of patient; patient's date of birth (month, day and year), and be sure to check the relationship to Policy/Certificate Holder block.

B. Policy/Certificate Holder Information (things to remember)

1. You must enter FULL first and last name, middle initial.
2. You must enter the correct and complete identification and group numbers for claim to be processed.
3. You must enter the correct and complete address for mailing of payment.

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