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 Mo. ____ Day ____ Yr. ____

Sex ☐ Male ☐ Female | Patient's Relationship to Policyholder ☐ Self ☐ Spouse ☐ Child ☐ Other (Specify)

Description of illness or injury requiring treatment.
Date Illness Began: Mo. ____ Day ____ Yr. ____

Was this an accident? ☐ Yes ☐ No | If yes, date of accident Mo. ____ Day ____ Yr. ____ | Was this an automobile accident? | Was the illness/accident related to employment? ☐ Yes ☐ No

Is patient a full time student? ☐ Yes ☐ No | If yes, what school?

OTHER INSURANCE

THIS PART MUST BE COMPLETED IN FULL BEFORE WE CAN DETERMINE RESPONSIBILTIES FOR YOUR CLAIM.

Do you have Medicare?
Part A: ☐ No ☐ Yes; Effective Date _____
Part B: ☐ No ☐ 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.

Is the patient covered by other medical insurance? ☐ No ☐ Yes

If yes, and the policy is with a group (such as through an employer), please complete the following scetion.

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: ☐ Single ☐ Family | Has the other insurance company paid? ☐ Yes ☐ 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.

Form No. HA72-01

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
      2. Drug Bills or Blue Cross Pharmacist's Statement
      3. Nurse's Bills
      4. Physical Therapy & Speech Therapy Bills
      5. Ambulance Bills
      6. Hospital Bills
      7. Durable Medical 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. acist'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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