BlueCross BlueShield of Illinois

Claim Form
to Pay Insured/Subscriber

P.O. Box 805107 • Chicago, Illinois 60680-4112

Each item on this form needs to be completed.
Instructions for completion are listed on the reverse side.

Please print or type.

1

Insured/Subscriber Name (Last, First, Middle Initial)

Mailing Address

City and State | **ZIP Code**

Insured Employed? ☐ Yes ☐ No ☐ Retired — Date of Retirement: Month Day Year _____/_____/_____

2

Group Number | **Insured/Subscriber Identification Number** (from ID card)

Patient's Full Name (Last, First, Middle)

Patient's Sex | **Patient's Date of Birth** Month Day Year _____/_____/_____

Patient's Relationship to Insured

☐ Self ☐ Spouse ☐ Child ☐ Other (explain) _____

3

Type of treatment received:
Check only one type and attach itemized statements. Please use a separate claim form for each different type of treatment.

Please note: Preventive care includes immunizations, routine well baby care, routine physical examinations, vision and hearing exams.

Month Day Year

☐ Injury — Date of accident: _____/_____/_____
☐ Illness — Date of first symptom: _____/_____/_____
☐ Pregnancy — Date of conception: _____/_____/_____
☐ Preventive — Date of service: _____/_____/_____

4

Describe: Diagnosis, symptoms of illness or injury or explain preventive or routine care received.

_____
_____
_____

5

Was illness or injury work connected? ☐ Yes ☐ No

Name and address of employer

_____
_____

6

If injury, was a motor vehicle involved? ☐ Yes ☐ No

7

Is patient covered under any other health benefits plan (besides Medicaid, Medicare or CHAMPUS)? ☐ Yes ☐ No

Insurance Co. _____
Address _____ Effective date of coverage Month Day Year _____/_____/_____
Employer _____ Sex of Insured ☐ Male ☐ Female
Insured name _____ Date of birth of insured _____/_____/_____
Policy # _____ Relationship to patient _____

If the other coverage is primary, attach the other insurance company's Explanation of Benefits.

8

Medicare — Is the patient:

Month Day Year

a) Entitled to benefits under Medicare insurance (Part A)? ☐ Yes ☐ No Effective _____/_____/_____
b) Entitled to benefits under Medicare insurance (Part B)? ☐ Yes ☐ No Effective _____/_____/_____
c) Entitled to benefits under Medicare due to a disability? ☐ Yes ☐ No Effective _____/_____/_____

Patient's Medicare Identification Number. (From Medicare ID card) _____

9

I certify the above is complete and correct and that I am claiming benefits only for charges incurred by the patient named above. Authorization is hereby given to any Hospital, Physician, Dentist, Provider, Insurance Carrier or other entity to give Blue Cross and Blue Shield of Illinois, upon request, any medical information which the Plans in their judgment deem necessary to the adjudication of this claim. Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Signature of Insured | **Date** | **Daytime telephone number**

10

Total amount for ALL covered services and supplies received. **$**

Itemized Bill(s) for covered services and supplies must be attached. ***(See Instructions on reverse side.)***

BlueCross BlueShield of Illinois

Claim Form
to Pay Insured/Subscriber

INSTRUCTIONS

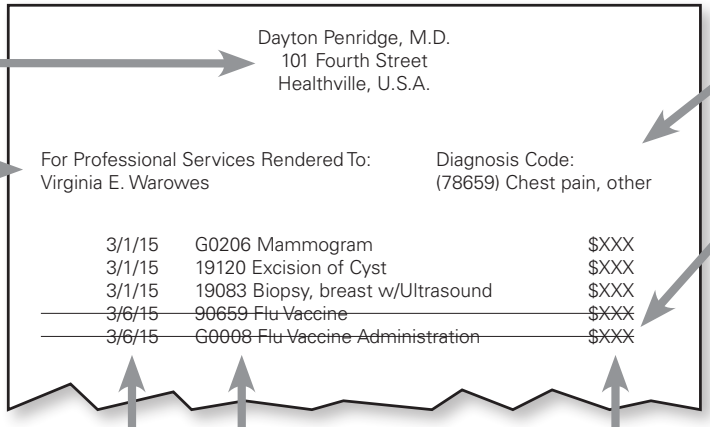
Important: DO NOT file this form if your Provider of Service is submitting these charges to Blue Cross and Blue Shield of Illinois.

Please complete every item on claim form.

1	Insured/subscriber's name, address and employment status	Please show the insured/subscriber's name exactly as it appears on the Blue Cross and Blue Shield of Illinois identification card and specify the current address including the ZIP code. Check appropriate box indicating the insured/subscriber's employment status. If retired, give date of retirement.
2	Patient information	Make sure the group number and identification number are exactly as shown on the insured's identification card. List patient's full name; no nicknames or initials. Check the appropriate blocks for the patient's sex and relationship to the insured. Ensure the patient's correct date of birth is shown.
3	Type of treatment received	Check only one treatment type (injury, illness, pregnancy or preventive care) and specify date of injury, date of first symptom, date of conception or date preventive care was received. You may attach multiple itemized statements if they are for one type of treatment (example: illness only, preventive care only).
4	Diagnosis or symptoms of illness or injury	Give diagnosis or a brief description of symptoms. If preventive care services were received, state the type of care (routine physical, hearing exam, vision exam, immunization or diagnosis, etc.).
5	If illness or injury is in any way work-related	Check appropriate box and enter name and address of employer.
6	If motor vehicle injury	Check appropriate box.
7	Other insurance	Please check appropriate box. If "yes," complete the required information.
8	Medicare information	Please check appropriate box concerning Medicare eligibility. If "yes," show effective date and give Medicare identification number. Medicare Enrollees should include a copy(s) of the Medicare Explanation of Benefits Form(s) (EOB) with their itemized statements unless patient is actively employed and requires group coverage to pay primary.
9	Insured's signature, date and daytime telephone number	Please sign and date this form and attach your physician's itemized letterhead statement(s). The itemized statement(s) should contain all the information shown in the following example:

10

Example of Itemized Bill — Please remember to attach the original bill(s) to the claim form and make a copy for your records. Itemized bills cannot be returned.



Name of the person or organization providing the services or supplies.

Name of the patient receiving the services or supplies

If you are submitting itemized bills for a variety of services please use a separate claim form for each different type of treatment (one for illness, another for an injury, etc.).

Please cross out those charges which were included on a previous claim.

NOTE: Bills for Private Duty Nursing Service must show the professional status of the nurse (R.N. — Registered Nurse, L.V.N. — Licensed Vocational Nurse), the nurse's license number, and must be accompanied by a statement from your physician indicating medical necessity and daily nurse's progress notes.

Date each service or supply was provided

Description of the services or supplies provided

Charge for each service or supply

FOR OTHER THAN PRESCRIPTION DRUG CARD HOLDERS: Bills for Prescription Drugs must show the name of each drug, the prescription number, the quantity dispensed, the date of purchase, and the amount charged for each drug, If drug is generic then the pharmacist must also indicate on itemized bill.

This completed form, together with the itemized bills, should be submitted to:

Blue Cross and Blue Shield of Illinois
P.O. Box 805107
Chicago, Illinois 60680-4112

BlueCross BlueShield of Illinois

If you, or someone you are helping, have questions, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 855-710-6984.

العربية Arabic	إن كان لديك أو لدى شخص تساعده أسئلة، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة. للتحدث مع مترجم فوري، اتصل على الرقم 855-710-6984.
繁體中文 Chinese	如果您, 或您正在協助的對象, 對此有疑問, 您有權利免費以您的母語獲得幫助和訊息。洽詢一位翻譯員, 請撥電話 號碼 855-710-6984。
Français French	Si vous, ou quelqu'un que vous êtes en train d'aider, avez des questions, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 855-710-6984.
Deutsch German	Falls Sie oder jemand, dem Sie helfen, Fragen haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 855-710-6984 an.
Ελληνικά Greek	Εάν εσείς ή κάποιος που βοηθάτε έχετε ερωτήσεις, έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας χωρίς χρέωση. Για να μιλήσετε σε έναν διερμηνέα, καλέστε 855-710-6984.
ગુજરાતી Gujarati	જો તમને અથવા તમે મદદ કરી રહ્યા હોય એવી કોઈ બીજી વ્યક્તિને એસ.બી.એમ. કાર્યક્રમ બાબતે પ્રશ્નો હોય, તો તમને વિના ખર્ચે, તમારી ભાષામાં મદદ અને માહિતી મેળવવાનો હક્ક છે. દુભાષિયા સાથે વાત કરવા માટે આ નંબર 855-710-6984 પર કૉલ કરો.
हिंदी Hindi	यदि आपके, या आप जिसकी सहायता कर रहे है उसके, प्रश्न है, तो आपको अपनी भाषा मे निःशुल्क सहायता और जानकारी प्राप्त करने का अधिकार है। किसी अनुवादक से बात करने के लिए 855-710-6984 पर कॉल करें ।.
Italiano Italian	Se tu o qualcuno che stai aiutando avete domande, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare il numero 855-710-6984.
한국어 Korean	만약 귀하 또는 귀하가 돕는 사람이 질문이 있다면 귀하는 무료로 그러한 도움과 정보를 귀하의 언어로 받을 수 있는 권리가 있습니다. 통역사가 필요하시면 855-710-6984 로 전화하십시오.
Diné Navajo	T'áá ni, éí doodago ła'da bíká anánílwo'ígíí, na'ídíłkidgo, ts'ídá bee ná ahóóti'i' t'áá níík'e níká a'doolwoł dóó bína'ídíłkidígíí bee nił h odoonih. Ata'dahalne'ígíí bich'į' hodíílnih kwe'é 855-710-6984.
Polski Polish	Jeśli Ty lub osoba, której pomagasz, macie jakiekolwiek pytania, macie prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer 855-710-6984.
Русский Russian	Если у вас или человека, которому вы помогаете, возникли вопросы, у вас есть право на бесплатную помощь и информацию, предоставленную на вашем языке. Чтобы связаться с переводчиком, позвоните по телефону 855-710-6984.
Español Spanish	Si usted o alguien a quien usted está ayudando tiene preguntas, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 855-710-6984.
Tagalog Tagalog	Kung ikaw, o ang isang taong iyong tinutulungan ay may mga tanong, may karapatan kang makakuha ng tulong at impormasyon sa iyong wika nang walang bayad. Upang makipag-usap sa isang tagasalin-wika, tumawag sa 855-710-6984.
اردو Urdu	اگر آپ کو، یا کسی ایسے فرد کو جس کی آپ مدد کررہے ہیں، کوئی سوال درپیش ہے تو، آپ کو اپنی زبان میں مفت مدد اور معلومات حاصل کرنے کا حق ہے۔ مترجم سے بات کرنے کے لیے، 855-710-6984 پر کال کریں۔
Tiếng Việt Vietnamese	Nếu quý vị, hoặc người mà quý vị giúp đỡ, có câu hỏi, thì quý vị có quyền được giúp đỡ và nhận thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, gọi 855-710-6984.

BlueCross BlueShield of Illinois

Health care coverage is important for everyone.

We provide free communication aids and services for anyone with a disability or who needs language assistance.
We do not discriminate on the basis of race, color, national origin, sex, gender identity, age, sexual orientation, or disability.

To receive language or communication assistance free of charge, please call us at 855-710-6984.

If you believe we have failed to provide a service, or think we have discriminated in another way, contact us to file a grievance.

Office of Civil Rights Coordinator
300 E. Randolph St.
35th Floor
Chicago, Illinois 60601

Phone: 855-664-7270 (voicemail)
TTY/TDD: 855-661-6965
Fax: 855-661-6960
Email: CivilRightsCoordinator@hcsc.net

You may file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, at:

U.S. Dept. of Health & Human Services
200 Independence Avenue SW
Room 509F, HHH Building 1019
Washington, DC 20201

Phone: 800-368-1019
TTY/TDD: 800-537-7697
Complaint Portal: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Complaint Forms: http://www.hhs.gov/ocr/office/file/index.html