Claim Form

BlueCross BlueShield of Kansas

This form does not need to be completed if your services were provided by a contracting hospital, physician or dentist. These contracting providers will file a claim on your behalf.

Section 1 – Patient Information

CLEAR DATA

First Name _____ MI _____ BCBSKS Identification Number _____ Group Number _____

Last Name _____ Suffix _____ Date of Birth _____ / _____ / _____

Residential Address _____ (_____) _____-_____ Home Phone Number (_____) _____-_____ Cell Phone Number

City _____ (_____) _____-_____ Work Phone Number (_____) _____-_____ Fax Number

State _____ ZIP Code _____ +4 _____ E-mail Address _____

☐ Change of address: If the address above is a different address, please check this box.

Section 2 – Alternate Payee Information

Please complete this section if someone other than the cardholder is to be reimbursed.

First Name _____ MI _____ (_____) _____-_____ Home Phone Number (_____) _____-_____ Cell Phone Number

Last Name _____ Suffix _____ (_____) _____-_____ Work Phone Number (_____) _____-_____ Fax Number

Address _____ E-mail Address _____

City _____

State _____ ZIP Code _____ +4 _____

Section 3 – Information About Your Injury or Illness

Is this service related to an accident? ☐ Yes ☐ No

If yes, please complete the following information:

_____ / _____ / _____
Date of Accident

How did the accident occur?

Accident occurred at: ☐ Home ☐ School ☐ Work ☐ Other _____

Was this injury/illness the result of occupational circumstances for which Workmen's Compensation is liable? ☐ Yes ☐ No

Has a Workmen's Compensation claim been filed? ☐ Yes ☐ No

If no, why not? _____

Section 4 – Motor Vehicle Injuries

Was the injury the result of physical contact with a motor vehicle? ☐ Yes ☐ No

If yes, please complete the following information:

Type of motor vehicle involved _____

If this was a motorcycle accident, do you have No Fault Motor Vehicle Insurance? ☐ Yes ☐ No

Your auto insurance has a maximum dollar limitation on benefits payable for medical expenses. Please contact your auto insurance company and provide the following:

- Personal injury protection maximum dollar amount
- Excess medical benefits maximum dollar amount
- Complete itemized statement indicating provider of service, date of service, and to whom paid.

Please continue on the next page.

Section 5 – Other Group Health Insurance

Is the patient entitled to benefits from any other group health insurance? ☐ Yes ☐ No

If yes, please complete the following information:

Name of Other Insurance Carrier

Certificate or Policy Number

Residential Address

Effective Date _____ / _____ / _____

Cancellation Date _____ / _____ / _____

City

Name of family member in whose name the policy is carried

State ZIP Code +4

Name of employer of family member named above

Section 6 – Medicare Coverage

Is the patient entitled to benefits under Medicare hospital insurance (Part A)? ☐ Yes ☐ No

If yes, please complete the following information:

Effective Date _____ / _____ / _____

Medicare ID Number

Name on Medicare card

Is the patient entitled to benefits under Medicare medical insurance (Part B)? ☐ Yes ☐ No

If yes, please complete the following information:

Effective Date _____ / _____ / _____

Medicare ID Number

Name on Medicare card

Is the patient entitled to benefits under Medicare prescription drug insurance (Part D)? ☐ Yes ☐ No

If yes, please complete the following information:

Effective Date _____ / _____ / _____

Medicare ID Number

Name on Medicare card

Section 7 – Additional Information and Authorization

For prescription drug claims: File one claim per patient and attach an itemized bill from the pharmacy with the pharmacist's signature or the pharmacy receipts. Do not send cash register receipts. The proof of service must include patient's name, prescription name and prescription Rx number, NDC code, quantity, number of days supply, service date, cost for each prescription plus the complete name and address of the pharmacy, and the pharmacy tax ID number.

For all other services: File one claim per patient and attach an itemized bill from the service provider. The itemization must include the patient's name, the service provided, service date, cost for each service, diagnosis, and the provider's name and tax ID number. Please complete a separate claim form in full for each hospital and/or doctor bill being submitted.

Prompt filing of claims: Notice of your claim must reach Blue Cross and Blue Shield of Kansas within one (1) year and ninety (90) days from the date services were received. Submit this claim to:

Blue Cross and Blue Shield of Kansas
1133 SW Topeka Boulevard, Topeka, KS 66629-0001

I represent that the information on this form is correct and that I am claiming benefits only for charges incurred by the patient named on this form.

Your signature required

Applicant (Signature of parent/guardian if other than applicant)

Date Signed _____ / _____ / _____

Print Name

If you have questions regarding this form, call:

Blue Cross and Blue Shield of Kansas
(785) 291-4180
Toll free: 1-800-432-3990

State of Kansas employees
(785) 291-4185
Toll free: 1-800-332-0307

To order additional forms, call:

Teleorder
(785) 291-8130
Toll free: 1-800-346-2227
or visit our website: bcbsks.com

This information is being furnished in compliance with applicable federal regulations.

This Notice has important information. This notice has important information about your application or coverage through Blue Cross and Blue Shield of Kansas. Look for key dates in this notice. You may need to take action by certain deadlines to keep your health coverage or help with costs. You have the right to get this information and help in your language at no cost. Please call 1-800-432-3990.

Discrimination is against the law.

Blue Cross and Blue Shield of Kansas (BCBSKS) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. BCBSKS does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Blue Cross and Blue Shield of Kansas:
- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Holly Graves.

If you believe that BCBSKS has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Holly Graves, Director, Individual Sales and Customer Service, 1133 S.W. Topeka Blvd., Topeka, KS 66629-0001,
1-800-432-3990, TTY: 1-800-766-3777, Fax: 785-290-0711, CSC@bcbsks.com.

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Holly Graves is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Para obtener asistencia en español, llame al servicio de atención al cliente al número que aparece en su tarjeta de identificación.

請撥打您 ID 卡上的客服號碼以尋求中文協助。

Gọi số dịch vụ khách hàng trên thẻ ID của quý vị để được hỗ trợ bằng Tiếng Việt.

한국어로 도움을 받고 싶으시면 ID 카드에 있는 고객 서비스 전화번호로 문의해 주십시오.

Para sa tulong sa Tagalog, tumawag sa numero ng serbisyo sa customer na nasa inyong ID card.

Обратитесь по номеру телефона обслуживания клиентов, указанному на Вашей идентификационной карточке, для помощи на русском языке.

اتصل برقم خدمة العملاء الموجود على بطاقة هُويتك للحصول على المساعدة باللغة العربية.

Rele nimewo sèvis kliyantèl ki nan kat ID ou pou jwenn èd nan Kreyòl Ayisyen.

Pour une assistance en français du Canada, composez le numéro de téléphone du service à la clientèle figurant sur votre carte d'identification.

Ligue para o número de telefone de atendimento ao cliente exibido no seu cartão de identificação para obter ajuda em português.

Aby uzyskać pomoc w języku polskim, należy zadzwonić do działu obsługi klienta pod numer podany na identyfikatorze.

日本語でのサポートは、ID カードに記載のカスタマーサービス番号までお電話でお問い合わせください。

Per assistenza in italiano chiamate il numero del servizio clienti riportato nella vostra scheda identificativa.

Rufen Sie den Kundendienst unter der Nummer auf Ihrer ID-Karte an, um Hilfestellung in deutscher Sprache zu erhalten.

برای دریافت راهنمایی به زبان فارسی ، با شماره خدمات مشتری که بر روی کارت شناسایی شما درج شده است تماسبگیرید..