

# Claim Form



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**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.**

**For prescription drug claims:** File one claim per patient and attach an itemized bill from the pharmacy 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.

**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 and diagnosis. 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.

Section 1

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Last First MI MM/DD/YYYY

Identification No. \_\_\_\_\_ Group No. \_\_\_\_\_

Home Address \_\_\_\_\_  
Street  
\_\_\_\_\_  
City State ZIP Code

Home Phone No. \_\_\_\_\_ Mobile Phone No. \_\_\_\_\_  
Area Code Area Code

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.

Alt. Payee Name \_\_\_\_\_  
Last First MI

Alt. Payee Address \_\_\_\_\_  
Street  
\_\_\_\_\_  
City State ZIP Code

Alt. Payee Home Phone No. \_\_\_\_\_ Mobile Phone No. \_\_\_\_\_  
Area Code Area Code

Section 3

Describe the reason for treatment: \_\_\_\_\_

**Is this service related to an accident?**  Yes  No If yes, complete the following:

Date of Accident \_\_\_\_\_

How did the accident occur? \_\_\_\_\_

Where did the accident occur?  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? \_\_\_\_\_

Please continue on other side. →

Section 4

Was the injury the result of physical contact with a motor vehicle?  Yes  No If yes, complete the following:

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.

Section 5

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

If yes, complete the following:

Name of other insurance carrier \_\_\_\_\_

Address of other insurance carrier \_\_\_\_\_

Certificate or policy number \_\_\_\_\_

Effective Date \_\_\_\_\_ Cancellation Date \_\_\_\_\_

Name of family member in whose name the policy is carried \_\_\_\_\_

Name of employer of family member named above \_\_\_\_\_

Section 6

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

If yes, effective date is \_\_\_\_\_ ID# \_\_\_\_\_  
MM/DD/YYYY

Name on Card \_\_\_\_\_

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

If yes, effective date is \_\_\_\_\_ ID# \_\_\_\_\_  
MM/DD/YYYY

Name on Card \_\_\_\_\_

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

If yes, effective date is \_\_\_\_\_ ID# \_\_\_\_\_  
MM/DD/YYYY

Name on Card \_\_\_\_\_

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.

Signature

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

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 toll free at 1-800-346-2227, in Topeka at (785) 291-8130, or visit our Web site at [www.bcbsks.com](http://www.bcbsks.com)