

# MEMBER CLAIM FORM

For status of claim information visit our website - [www.bcbsks.com](http://www.bcbsks.com)

**To be completed by member. Be sure to attach itemized invoices from provider and complete itemizations starting on page 3. Bills will not be returned.**



1. Member name \_\_\_\_\_  
Last First MI  
 Group number \_\_\_\_\_ Identification number \_\_\_\_\_

2. Home address \_\_\_\_\_  
Street  
 \_\_\_\_\_  
City State ZIP Phone No.

Please check here if this is a change of address.

3. Was any treatment the result of ACCIDENTAL injury?  Yes  No **If yes, complete (a) and (b).**  
 (a) Was this the result of a motor vehicle or motorcycle accident?  Yes  No If yes, please provide your agent's name, address and telephone number. \_\_\_\_\_  
 (b) If treatment to any patient was the result of an accident, give the name of the patient(s) and date(s) of accident.

Name of Patient	Nature of Accident	Type (Auto or Home)	Date of Accident		
			Month	Day	Year
Example John	Fell off of bike	Home	9	1	04

Was any illness or injury work related?  Yes  No **If yes, complete the following.**

Name of Patient	Name of Employer	Employer Address

4. Is any patient covered under any other group health insurance plan or has coverage changed (due to divorce, etc.)?  
 Yes  No (If Yes, complete the following.)  
 Policyholder's name \_\_\_\_\_ Policy number \_\_\_\_\_  
 Patient's name \_\_\_\_\_  
 Insurance company \_\_\_\_\_  
 Address of company \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

NOTE: If your other insurance company has processed your claim, please attach their explanation of benefits to this claim form in addition to any itemized bills you may have from the provider.

5. Is any patient entitled to benefits under Medicare hospital insurance (Part A)?  Yes  No  
 If yes, effective date is      /      /      ID #      Name       
MM DD YY  
 Is any patient entitled to benefits under Medicare medical insurance (Part B)?  Yes  No  
 If yes, effective date is      /      /      ID #      Name       
MM DD YY

I certify the information on this form is correct and that I am claiming benefits only for charges incurred by the patient(s) **itemized** on this form.

**X** \_\_\_\_\_  
 Signature of member Date

# Instructions for completion of the "Summary of Itemized Bills"

In order to ensure fast and accurate processing of your claim and help hold down health care costs, please make sure the itemization is complete and accurate. See the illustration.

1. List each patient separately:
  - a. Patient's full name
  - b. Month, day and year of birth
  - c. Relationship of patient to member
2. List all services individually in service date order.
  - a. Be specific with description of services.
  - b. **Be sure to include drug name, the NDC # (National Drug Code), Days Supply and Quantity of each prescription drug listed.**

Summary Of Itemized Bills							
You <b>must</b> itemize your expenses for each patient separately. All itemized bills <b>must</b> be attached. <b>Completion of this section is a requirement for filing</b> and will speed the processing of your claim.							
Accident/ME Date MO DAY YR	Identification Number	Patient Name (First)	(MI)	(Last)	Birth Date Mo/Day/Yr	Relationship (Self, Spouse, Son, Daughter, other)	
8   21   04	651824123	Susan	B	Hadley	8/10/59	Spouse	
Name of Physician, Hospital, Pharmacy or other Provider of Service	Description of service, if drug include name, days supply and quantity	National Drug Code (NDC #)	Date of Service Mo/Day/Yr	Units	Amount of Charge	Diagnosis	
Dr. James Smith	Thyroid Panel		8-19-04		\$6.00	Testing for Thyroid	
Dr. James Smith	Blood Culture		8-19-04		\$11.00	Testing for Thyroid	
Dr. Mark Warner	<small>Accident: 8-21-03</small> Tetanus Shot		8-21-04		\$10.00	Stepped on Nail	
Dr. Mark Warner	Penicillin Injection		8-22-04		\$8.00	Stepped on Nail	
Dr. Mark Warner	X-ray Hand + Wrist		<small>Accident: 1-7-04</small> 1-7-04		\$15.00	Shut hand in door	
Dr. Mark Warner	<small>Accident: 1-7-03</small> Office Visit		1-8-04		\$20.00	Shut hand in door	
Stanley's Rexall Drug	<small>30 days supply, Qty 100</small> Tylenol w/ Codeine	00045-0508-16	12-30-04		\$14.40	Pain in Back	
<small>Johnson's</small> Prescription Center	<small>34 days supply, Qty 34</small> Inderal	00046-0421-60	12-30-04		\$30.50	High Blood Pressure	

3. Make sure the service date listed is the **actual date** you received treatment and **not** the billing date, payment date, or receipt date.
4. List the specific diagnosis for each date of service.
5. **Invoices or individual bills must** be included for each service submitted. Itemized bills for prescriptions should include drug name, National Drug Code (NDC #), quantity and days supply. (Cash register receipts, balances on accounts or cancelled checks are **not** acceptable.)
6. List **only** those services for which you are requesting reimbursement.
7. If services are due to an accident, be sure to indicate the accident date and nature of accident beside each service involved.
8. **Prompt filing of claims** - Notice of your claim must be given to Blue Cross and Blue Shield of Kansas within one (1) year and ninety (90) days of the date from which your services were received.
9. **Special instructions for Medicare patients** - When the patient is covered under Medicare hospital insurance (Part A), the "Notice of Health Insurance Utilization" form (or copy of the form) pertaining to charges you are now claiming, must be enclosed with this claim form. When the patient is covered under Medicare medical insurance (Part B), the "Explanation of Medicare Benefits" form (or a copy of the form), pertaining to charges you are now claiming, must be enclosed with this form.
10. Send this completed form, together with itemized bills and supporting materials to:  
 Blue Cross and Blue Shield of Kansas  
 1133 S.W. Topeka Boulevard - Topeka, Kansas 66629-0001  
 (Additional claim forms can be obtained by contacting the Blue Cross and Blue Shield of Kansas office in your area.)

# Summary Of Itemized Bills

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Accident/ME Date	MO	DAY	YR	Identification Number	Patient Name (First)	(MI)	(Last)	Birth Date Mo/Day/Yr	Relationship (Self, Spouse, Son, Daughter, other)

Name of Physician, Hospital, Pharmacy or other Provider of Service	Description of service, if drug include name, days supply and quantity	National Drug Code (NDC #)	Date of Service Mo/Day/Yr	Units	Amount of Charge	Diagnosis

Accident/ME Date	MO	DAY	YR	Identification Number	Patient Name (First)	(MI)	(Last)	Birth Date Mo/Day/Yr	Relationship (Self, Spouse, Son, Daughter, other)

Name of Physician, Hospital Pharmacy or other Provider of Service	Description of service, if drug include name, days supply and quantity	National Drug Code (NDC #)	Date of Service Mo/Day/Yr	Units	Amount of Charge	Diagnosis

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