

GENERAL INSTRUCTIONS FOR COMPLETING THIS CLAIM FORM

We want to process your claim promptly and accurately...but we need your help to do so. Please read these instructions before completing the other side. This form should be used only when submitting a claim for the services of a non-participating health care provider from whom you have received services.

1. A separate claim form should be completed for each member of the family for whom expenses are being reported. The expenses on the claim should be for services from one provider and should be for dates of service in the same calendar year. Submit separate claims for each provider and each year.
2. An itemized bill must be attached to the claim form when you send it to us. The itemized bill must show the patient's name, the provider name, the date each service was rendered, the type of each service, and charge for each service or supply. Pharmacy bills should also show the prescription number and the name of the drug. Cash register receipts, cancelled checks, or bills saying only "For Services Rendered" are not acceptable. **THE BILLS MUST BE ITEMIZED.** Since the bills will not be returned to you, you may want to make copies to attach to your copy of the claim form.
3. This is a two-part carbonless form, retain the yellow copy for your records. Submit the original along with the itemized statement(s) to the local Blue Cross Blue Shield office. If you are located in the Kansas City area send to **Blue Cross and Blue Shield of Kansas City, PO Box 419169, Kansas City, MO 64141-6169**. If you are located outside of the Kansas City area, please call the customer service phone number located on your ID card to obtain the address for the nearest BCBS office.
4. **ADDITIONAL CLAIM FORMS ARE AVAILABLE** from your group leader if your coverage is sponsored by your employer; otherwise, contact Customer Service (816) 395-2222.
5. Claims should be filed throughout the year as warranted by expenses, but must be filed within 365 days after the end of the calendar year in which the service is received.
6. Do not write in the areas designated for office use only.

YOUR GUIDE TO COMPLETING THIS FORM

Please Do Not Submit Claims For HMO, Preferred or Participating Providers

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| 1. PATIENT'S NAME—Print first name, middle initial, last name.
Example: Jane Q. Doe. | 12. IS THE PATIENT ELIGIBLE FOR MEDICARE—Check appropriate box. If yes, copy number from your Medicare Health Insurance card. Show the amount paid by Medicare and attach the Explanation of Medicare Benefits to this form when you submit your claim. |
| 2. PATIENT'S BIRTHDATE—Show in numbers. Example 8/25/70. | 13. EMPLOYEE/POLICYHOLDER—The name of the group employee or individual policyholder responsible for the membership. |
| 3. PATIENT'S SEX—Check appropriate box. | 14. EMPLOYEE/POLICYHOLDER ADDRESS—Show post office box number or apartment number if applicable, and street, city, state, and ZIP code. |
| 4. PATIENT'S RELATIONSHIP TO SUBSCRIBER—Check appropriate box. | 15. SIGNATURE OF EMPLOYEE/POLICYHOLDER—The employee/policy holder (not the patient) must sign this claim form. Also include date claim form is signed. |
| 5. IS ILLNESS OR INJURY DUE TO PATIENT'S EMPLOYMENT—Check appropriate box. | 16. DESCRIBE THE ILLNESS OR INJURY—Identify each illness or injury for which this claim is being filed.

Claims for payment of expenses related to accidents must not be combined with claims for payment of other illnesses. |
| 6. IS CLAIM DUE TO ACCIDENT—Check appropriate box. | 17. REFERRING PHYSICIAN—If your physician referred you to this provider, please give the physician's name. |
| 7. MEMBER ID NUMBER—Copy the number from your Blue Cross and Blue Shield membership card. Include the 3-digit alpha prefix. | 18. TOTAL CHARGES—Indicate the total amount of the charges on this bill. Be sure the itemized bill for all covered services is attached when you send us this claim form. |
| 8. GROUP NUMBER—Copy the number from your Blue Cross and Blue Shield membership card. | 19. PATIENT PAID AMOUNT—If you have paid all or part of the bill, show the amount you have paid. |
| 9. AUTO ACCIDENT—Check appropriate box. | |
| 10. DATE OF ACCIDENT—If services are related to an accident, show the date of the accident in numbers.
DATE OF ILLNESS—If services are related to an illness, show the date the illness began.
DATE OF LMP—If the services are related to pregnancy, show the date of the last menstrual period. | |
| 11. DOES PATIENT HAVE OTHER GROUP COVERAGE—Check appropriate box. If yes, print name of insurance company, identification number, group number and the amount paid by the other insuring agency. | |

Claim Information—Attach your Itemized Bill to the Claim Form

Please attach the itemized bill to the claim form when you submit it to us. **Do not write in the area of the form designated for office use.**

20. PROVIDER NAME AND ADDRESS—Show the name and address of the physician, hospital or other institution which provided the services. **Do not submit claims for preferred or participating providers.** They will submit all claims to us for you. Only one bill should be submitted for each provider on each claim form except for pharmacies. Pharmacy bills for accidents may be combined and submitted on one claim as "drugs-accident." All other pharmacy bills may be combined and submitted as "drugs-illness."

Note: Do not include expenses for drugs which can be purchased without a doctor's prescription, such as aspirin, even though your doctor may have prescribed them for you. Such drugs are not covered by this program.