



Arkansas Blue Cross Blue Shield

An Independent Licensee of the Blue Cross and Blue Shield Association

601 Gaines
 P.O. Box 2181
 Little Rock, Arkansas 72203-2181

CLAIM FORM

A SEPARATE CLAIM FORM MUST BE SUBMITTED FOR EACH PATIENT WHEN SENDING BILLS TO ARKANSAS BLUE CROSS AND BLUE SHIELD

Please refer to the instructions on back of this form when filing your claims.

ARKANSAS BLUE CROSS AND BLUE SHIELD IDENTIFICATION NUMBER _____ GROUP NUMBER _____
 (as indicated on your identification card including the three-digit prefix)

PATIENT'S INFORMATION	Patient's Last Name		Complete First Name		Initial	Date of Birth Mo. ____ Day ____ Yr. ____		
	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		Patient's Relationship to Policy/Certificate Holder <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other (Specify)					
	Description of illness or injury requiring treatment.						Date Illness Began: Mo. ____ Day ____ Yr. ____	
	Was this an accident? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, date of accident Mo. ____ Day ____ Yr. ____		Was this an automobile accident?		Was the illness/accident related to employment? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Is patient a full time student? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, what school?					
OTHER INSURANCE	THIS PART MUST BE COMPLETED IN FULL BEFORE WE CAN DETERMINE RESPONSIBILITIES FOR YOUR CLAIM.							
	Do you have Medicare? Part A: <input type="checkbox"/> No <input type="checkbox"/> Yes; Effective Date _____ Part B: <input type="checkbox"/> No <input type="checkbox"/> Yes; Effective Date _____					If yes, please file the claim with Medicare first. Then submit a copy of your Explanation of Medicare Benefits with this form.		
	Is the patient covered by other medical insurance? <input type="checkbox"/> No <input type="checkbox"/> Yes					If yes, and the policy is with a group (such as through an employer or Farm Bureau), please complete the following section.		
	Name of insured policyholder:			Name and address of insured's employer:				
	Name and Address of other insurance company:					Policy Number (other insurance co.)		
	Type of Coverage: <input type="checkbox"/> Single <input type="checkbox"/> Family		Has the other insurance company paid? <input type="checkbox"/> Yes <input type="checkbox"/> No					If yes, please submit a copy of their payment information with this form.
POLICY/CERTIFICATE HOLDER'S INFORMATION	Policy/Certificate Holder's Last Name		First Name		Initial	Policy/Certificate Holder's Employer		
	Policy/Certificate Holder's Address							
	Street		City			State		Zip
	I certify the above is complete and correct and that I am claiming benefits for charges incurred by the above named patient.							
Policy/Certificate Holder's Signature _____					Date _____			

IF YOU HAVE ANY QUESTIONS, PLEASE CONTACT YOUR GROUP INSURANCE ADMINISTRATOR, YOUR LOCAL ARKANSAS BLUE CROSS AND BLUE SHIELD REGION, OR OUR CUSTOMER SERVICE REPRESENTATIVE IN LITTLE ROCK AT 378-2010.

GENERAL INFORMATION

You should submit your bills in a timely manner. To speed the processing of your claim, all bills must be itemized and attached to the claim form. ALL items on the claim form must be completed to insure proper payment.

NOTE: CANCELLED CHECKS, PAYMENT RECEIPTS, OR BALANCE FORWARD BILLS ARE NOT ACCEPTABLE

HOW TO FILE A CLAIM

1. PREPARATION OF BILLS

A. Separate bills into the following groups:

- | | | | |
|---|---|--------------------|--------------------|
| 1. Physician's Bills | 3. Nurse's Bills | 5. Ambulance Bills | 7. Durable Medical |
| 2. Drug Bills or Blue Cross
Pharmacist's Statement | 4. Physical Therapy &
Speech Therapy Bills | 6. Hospital Bills | Equipment Bills |
| | | | 8. Other Bills |

B. Check the bills for the following information:

1. Physician's Bills - (Must be submitted on physician's office bill or a Blue Shield claim form.)
 - a. Full name of patient
 - b. Date(s) of service
 - c. Full description of the type of procedures, medical services or supplies furnished for each date.
 - d. Amount charged for each service
 - e. Diagnosis
2. Drug Bills or Blue Cross Pharmacist's Statement - (Must be submitted on official pharmacy invoice or stationery)
 - a. Full name of patient
 - b. Date(s) of purchase
 - c. Prescription number
 - d. Amount charged for each prescription
 - e. Name of drug
3. Nurse's Bills - (Must have registration or license number of R.N. or L.P.N.)
 - a. Full name of patient
 - b. Professional status (i.e., R.N., or L.P.N., etc.) of each service
 - c. Beginning and ending dates of the nursing service
 - d. Time & number of hours worked
 - e. Charge for the nursing service
 - f. Nurse's name
4. Physical Therapy and Speech Therapy Bills - (Must be on therapist's stationery)
 - a. Full name of patient
 - b. Date(s) of service
 - c. Charge for each service
 - d. Name of licensed therapist
5. Ambulance Bills (Bills must be on ambulance firm's letterhead)
 - a. Full name of patient
 - b. Mileage of trip
 - c. Charges per mile
 - d. Points of departure and mileage
 - e. Description of other services (i.e., oxygen, equipment, etc.)
 - f. Charge for each service
 - g. Total amount charged
6. Hospital Bills
 - a. Itemized statement from hospital, which must include diagnosis
7. Durable Medical Equipment Bills - (Bill must include an invoice from the supplying firm) NOTE: On purchase of equipment, you must receive prior approval from Arkansas Blue Cross and Blue Shield to be eligible for payment
 - a. Full name of patient
 - b. Date(s) of services
 - c. Description of items
 - d. Charge for each item
 - e. Must have supporting statement from physician.
8. Other Bills - (Must include an invoice from the person or organization who provided the services)
 - a. Name of person or organization who provided the services
 - b. Full name of patient
 - c. Date the service was provided
 - d. Description of services
 - e. Charge for each service

NOTE:

DO NOT USE THIS FORM TO FILE CHARGES WHICH ARE BEING FILED FOR YOU BY THE HOSPITAL AND/OR PHYSICIAN. PLEASE CHECK WITH THE HOSPITAL AND/OR PHYSICIAN (OR OTHER PROVIDERS OF CARE) BEFORE FILING THE CLAIM YOURSELF.

2. PREPARATION OF CLAIM FORM

A. Patient information (things to remember)

1. Enter FULL name of patient; patient's date of birth (month, day and year), and be sure to check the relationship to Policy/Certificate Holder block.

B. Policy/Certificate Holder Information (things to remember)

1. You must enter FULL first and last name, middle initial.
2. You must enter the correct and complete identification and group numbers for claim to be processed.
3. You must enter the correct and complete address for mailing of payment.

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