

HEALTH BENEFITS CLAIM FORM



BlueCross BlueShield of South Carolina

An Independent Licensee of the Blue Cross and Blue Shield Association

Piedmont Service Center
Post Office Box 6000
Greenville, SC 29606-6000

1 Employee's Name
Identification Number
(Please include the letters if included on your ID Card)

2 Patient's Name
First Middle Initial Last

3 The Patient is: Female Male
And Is The: Employee Employee's Spouse Employee's Child

4 Patient's Date of Birth
Month Day Year

5 Employee's Mailing Address
Check If New Address
Street City State ZIP Code

6 Was any treatment required as a result of accidental injury? Yes No Date of accident

7 If an accident, was another person at fault? Yes No If yes, please explain.

Was any injury or illness work related? Yes No

8 Is the patient covered by Medicare Health Insurance, Part A? Yes No
Or by Supplemental Medical Insurance, Part B? Yes No
If yes, please attach your "Explanation of Medicare Benefits." It is necessary to process your claim.
Complete the following Medicare Health Insurance Benefit Number #

Is the patient covered under any other health benefit plan? Yes No
If yes, please attach your "Explanation of Benefits" from the other Insurance Company. Also, please complete this entire section as it is necessary to process this claim.

9 A. Policyholder's Name
Relationship of Policyholder to Patient
B. Name of other Policyholder's Employer
Address of other Policyholder's Employer
City State ZIP Code
C. Name of other Insurance Company
Address of other Insurance Company

CERTIFICATION OF MEMBER

10 I certify that the above information is correct and that the foregoing expenses were incurred for the above named patient. I request eligible benefits for these expenses. I authorize any physician, nurse, hospital or other provider or supplier in possession of records or information concerning the patient to furnish such information to Blue Cross and Blue Shield of South Carolina upon request. (Be sure to complete items 1-9 on this form and attach itemized statements for all expenses. Absence of this information may cause a delay in processing this claim.)

Date Employee's Signature

EXAMPLES OF
PHYSICIANS, MEDICAL EQUIPMENT, PHARMACIST AND NURSING BILLS

The following are properly filed itemized bills

MEDICAL AND SURGICAL BILLS

SHOULD INCLUDE THE FOLLOWING:

<p>(A) Physician name and address.</p> <p>(B) Full name of patient should appear on every bill, not just name of person paying bill.</p> <p>(C) The date of surgery or medical treatment.</p> <p>(D) The type of surgery performed or type of medical treatment.</p> <p>(E) Separate cost for each treatment.</p>	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="text-align: center;">(A)</td> <td style="text-align: center;">Harry Smith, M.D. Columbia, S.C.</td> </tr> <tr> <td style="text-align: center;">(B)</td> <td style="text-align: center;">Patient John Jones</td> </tr> <tr> <td style="text-align: center;">(C)</td> <td>9/18/96 9/17 - 23/96 10/23/96 12/1/96</td> </tr> <tr> <td style="text-align: center;">(D)</td> <td>Surgery, Appendectomy Hospital Calls Office Call Office Call-Virus Injection</td> </tr> <tr> <td style="text-align: center;">(E)</td> <td>250.00 No Charge No Charge 15.00 5.00</td> </tr> </table>	(A)	Harry Smith, M.D. Columbia, S.C.	(B)	Patient John Jones	(C)	9/18/96 9/17 - 23/96 10/23/96 12/1/96	(D)	Surgery, Appendectomy Hospital Calls Office Call Office Call-Virus Injection	(E)	250.00 No Charge No Charge 15.00 5.00
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MEDICAL EQUIPMENT

SHOULD INCLUDE THE FOLLOWING:

<p>(A) Full name of patient.</p> <p>(B) Name of Doctor ordering Medical Equipment.</p> <p>(C) Date Medical Equipment purchased.</p> <p>(D) Description of equipment purchased.</p> <p>Note:- Letter of medical necessity is required before major medical will process.</p>	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="text-align: center;">(A)</td> <td style="text-align: center;">ACE-BRACE Co. Columbia, S.C.</td> </tr> <tr> <td style="text-align: center;">(B)</td> <td style="text-align: center;">Patient Nancy Smith</td> </tr> <tr> <td style="text-align: center;">(C)</td> <td style="text-align: center;">Date 9/17/96</td> </tr> <tr> <td style="text-align: center;">(D)</td> <td style="text-align: center;">Address 2905 Start Rd. Dr. Jones</td> </tr> <tr> <td style="text-align: center;">(E)</td> <td style="text-align: center;">Phone 788-1234</td> </tr> <tr> <td style="text-align: center;">(F)</td> <td style="text-align: center;">Rx Wheelchair - Economy</td> </tr> <tr> <td style="text-align: center;">(G)</td> <td style="text-align: center;">Price 299.00</td> </tr> <tr> <td style="text-align: center;">(H)</td> <td style="text-align: center;">TAX 11.96</td> </tr> <tr> <td style="text-align: center;">(I)</td> <td style="text-align: center;">Total 310.96</td> </tr> </table>	(A)	ACE-BRACE Co. Columbia, S.C.	(B)	Patient Nancy Smith	(C)	Date 9/17/96	(D)	Address 2905 Start Rd. Dr. Jones	(E)	Phone 788-1234	(F)	Rx Wheelchair - Economy	(G)	Price 299.00	(H)	TAX 11.96	(I)	Total 310.96
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DRUGGIST BILLS

SHOULD INCLUDE THE FOLLOWING:

<p>(A) Full name of patient. (Separate bill should be submitted for each member of family for whom major medical expense benefits are being claimed.)</p> <p>(B) Date of purchase.</p> <p>(C) Prescription number, quantity, name and strength of drug.</p> <p>(D) Separate charge for each prescription.</p> <p>(E) Pharmacist's signature.</p>	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="text-align: center;">(A)</td> <td style="text-align: center;">PRICE PHARMACY 200 Market Street Columbia, S.C.</td> </tr> <tr> <td style="text-align: center;">(B)</td> <td style="text-align: center;">Patient: Mary G. Jones</td> </tr> <tr> <td style="text-align: center;">(C)</td> <td style="text-align: center;">Prescription Number Description 575-516 60 Aldoril25mg 588-152 60 HCTZ50mg 592-321 30 Aldoril25mg 599-472 60 Aldoril25mg</td> </tr> <tr> <td style="text-align: center;">(D)</td> <td style="text-align: center;">Charge 11.60 7.25 6.20 11.60</td> </tr> <tr> <td style="text-align: center;">(E)</td> <td style="text-align: center;">Signature Dr. G.S. Smith</td> </tr> <tr> <td style="text-align: center;">(F)</td> <td style="text-align: center;">Total 36.65</td> </tr> </table>	(A)	PRICE PHARMACY 200 Market Street Columbia, S.C.	(B)	Patient: Mary G. Jones	(C)	Prescription Number Description 575-516 60 Aldoril25mg 588-152 60 HCTZ50mg 592-321 30 Aldoril25mg 599-472 60 Aldoril25mg	(D)	Charge 11.60 7.25 6.20 11.60	(E)	Signature Dr. G.S. Smith	(F)	Total 36.65
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NURSING BILLS

SHOULD INCLUDE THE FOLLOWING:

<p>(A) Nursing bills must clearly indicate whether the nurse is a Registered Nurse (RN) or Licensed Practical Nurse (LPN). Also the license or Registry Number.</p> <p>(B) Name and address of patient.</p> <p>(C) Were nursing services provided in Hospital, Home or Elsewhere?</p> <p>(D) Dates worked.</p> <p>(E) Shift and/or hours worked.</p>	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="text-align: center;">(A)</td> <td style="text-align: center;">LICENSE OR REGISTRY NO. 12345</td> </tr> <tr> <td style="text-align: center;">(B)</td> <td style="text-align: center;">PLACE OF TREATMENT Home Care</td> </tr> <tr> <td style="text-align: center;">(C)</td> <td style="text-align: center;">ADDRESS 123 2nd St., Columbia, S.C.</td> </tr> <tr> <td style="text-align: center;">(D)</td> <td style="text-align: center;">DATES WORKED 12/8/96 12/9/96 12/10/96</td> </tr> <tr> <td style="text-align: center;">(E)</td> <td style="text-align: center;">SHIFTS/HOURS 7-3 p.m./8 hrs. 7-3 p.m./8 hrs. 11-7 a.m./8 hrs.</td> </tr> <tr> <td style="text-align: center;">(F)</td> <td style="text-align: center;">CHARGE 40.00 40.00</td> </tr> <tr> <td style="text-align: center;">(G)</td> <td style="text-align: center;">TOTAL HOURS 24 hrs.</td> </tr> </table>	(A)	LICENSE OR REGISTRY NO. 12345	(B)	PLACE OF TREATMENT Home Care	(C)	ADDRESS 123 2nd St., Columbia, S.C.	(D)	DATES WORKED 12/8/96 12/9/96 12/10/96	(E)	SHIFTS/HOURS 7-3 p.m./8 hrs. 7-3 p.m./8 hrs. 11-7 a.m./8 hrs.	(F)	CHARGE 40.00 40.00	(G)	TOTAL HOURS 24 hrs.
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