Hospital Indemnity Plan Claim Form

A separate claim must be submitted for each patient when sending bills.

Section 1

Member Information: (as it appears on your Blue Cross and Blue Shield of Kansas identification card)

Name ______ (Last) ______ (First) ______ (MI)

Address ______ (Street)

______ (City) ______ (State) ______ (ZIP Code)

Identification No. ______ Group No. ______

Is the above a change of address? ☐ Yes ☐ No

Date of Birth ____ / ____ / ____ (MM / DD / YYYY)

Section 2

Patient Information:

Name ______ (Last) ______ (First) ______ (MI)

Address ______ (Street)

______ (City) ______ (State) ______ (ZIP Code)

Gender ☐ Male ☐ Female

Date of Birth ____ / ____ / ____ (MM / DD / YYYY)

Relationship to Member ☐ Self ☐ Spouse ☐ Child ☐ Other

Nature of Illness ______

Diagnosis ______

Does this claim include Intensive Care Unit (ICU) or CardioCare Unit (CCU) services? ☐ Yes ☐ No

If yes, please indicate service dates: From ______ Through ______ Number of Days in ICU/CCU ______

Is claim a result of an accidental injury? ☐ Yes ☐ No Accident Date ______

Date of service on bills submitted: Earliest Date ______ Last Date ______

Section 3

Report of Services: (attach itemized bill)

Date of Service	Place of Service (use codes below)	Description of surgical or medical services received

O – Doctor's Office H – Patient's Home IN – Inpatient Hospital OH – Outpatient Hospital EC – Extended Care Facility OL – Other Location

Were any of the hospital stays listed above in a skilled nursing or rehabilitation hospital? ☐ Yes ☐ No

Were any of the services in the above hospital stays for:

Acupuncture ☐ Yes ☐ No

Sexual Misfunctions ☐ Yes ☐ No

Nervous and Mental Conditions ☐ Yes ☐ No

Dental Care ☐ Yes ☐ No

Convalescent Care ☐ Yes ☐ No

An Independent Licensee of the Blue Cross and Blue Shield Association.

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Section 3

General Information:

All claims need to be submitted within one (1) year and ninety (90) days of the date from which your services were received. To speed the processing of your claim, you should file once every three (3) months. A new claim form will be sent to you when any claims payment is made.

Preparation of bills:

All hospital bills must be itemized and attached to the claim form.

Note: Cancelled checks, payment receipts or balance forward bills are not acceptable.

Preparation of claim form:

Member Information: things to remember

- The full first name, last name and middle initial MUST be entered. The correct and complete identification number (and group number, if applicable) MUST be entered for the claim to be processed.
- The correct and complete address MUST be entered for mailing of payment.

Patient Information: things to remember

- Enter full name of patient, patient's date of birth and be sure to check a "Relationship to Member" block.

Note: All items must be completed for this claim to be processed.

Mailing Address

To ensure proper handling, mail this claim to:

Blue Cross and Blue Shield of Kansas
1133 SW Topeka Boulevard
Topeka, KS 66629-0001

Customer Service

Our customer service center personnel are available to answer your questions at:

In Topeka: 291-4180

Toll-Free: 1-800-432-3990

Authorization to Release Information:

I represent that all statements made herein are complete and true to the best of my knowledge. I understand that if I fail to provide any material information or if I misrepresent any matieral fact, such omission or misrepresentation may result in the re-rating, termination or rescission of my health care coverage and/or criminal prosecution.

Patient's signature ______________________________ **Date** ____/____/____

(Parent/Guardian, if minor)