

# Claim Form

Qualified Medical Child Support



Kansas contracting hospitals and Kansas contracting physicians and dentists will report services they provide. For other services, complete this form.

**Attached your itemized bill** and send it to: Blue Cross and Blue Shield of Kansas, 1133 SW Topeka Boulevard, Topeka, Kansas 66629-0001.

Itemized bills must be from the provider of service and must include the patient's name, service provided, service date, charge for each service and diagnosis. **Please complete a separate form in full for each hospital and/or doctor bill being submitted.** For prescription drug claims, please complete the Alternate Payee Prescription Drug Claim Form in addition to this form.

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.

Section 1

Member Name \_\_\_\_\_  
Last First MI

Identification No. \_\_\_\_\_ Group No. \_\_\_\_\_

Home Address \_\_\_\_\_  
Street

\_\_\_\_\_ City State ZIP Code

Home Phone No. \_\_\_\_\_  
Area Code

Section 2

**Alternate Payee Information:**

Change of Address: If the address above is a different address, please check this box.

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Alt. Payee Name \_\_\_\_\_  
Last First MI

Alt. Payee Address \_\_\_\_\_  
Street

\_\_\_\_\_ City State ZIP Code

Alt. Payee Phone No. \_\_\_\_\_  
Area Code

Section 3

Describe the illness or injury requiring treatment: \_\_\_\_\_

If treatment resulted from illness, give the dates the condition first appeared and when treatment was first sought \_\_\_\_\_  
 (if not the same, please give both dates)

**Is this service related to an accident?**  Yes  No If yes, complete the following:

Date of Accident \_\_\_\_\_

How did the accident occur? \_\_\_\_\_

Where did the accident occur?  Home  School  Work  Other \_\_\_\_\_

Did the accident occur in Kansas?  Yes  No If yes, what city and/or county? \_\_\_\_\_

If no, in what state did it occur? \_\_\_\_\_

Did this injury/illness occur on the job or on company property?  Yes  No

**Was this injury/illness the result of occupational circumstances for which Workmen's Compensation is liable?**  Yes  No

If yes, complete the following:

Date and description of injury/illness \_\_\_\_\_

Describe patient's job \_\_\_\_\_

Name and address of patient's employer \_\_\_\_\_

Sec. 3

Name and address of employer's Workmen's Compensation carrier \_\_\_\_\_

Has a Workmen's Compensation claim been filed?  Yes  No If no, why not? \_\_\_\_\_

**Was the injury the result of physical contact with a motor vehicle?**  Yes  No If yes, complete the following:

Date of Accident \_\_\_\_\_

Type of motor vehicle involved \_\_\_\_\_

If this was a motorcycle accident, do you have No Fault Motor Vehicle Insurance?  Yes  No

**Was this patient the driver, a passenger or a pedestrian?**  Driver  Passenger  Pedestrian

Name and address of your auto insurance company? \_\_\_\_\_

Did the accident involve any other vehicles?  Yes  No

If yes, what is the name and address of the owner and his/her insurance company?  
\_\_\_\_\_  
\_\_\_\_\_

Certificate or policy number \_\_\_\_\_

Your auto insurance has a maximum dollar limitation on benefits payable for medical expenses. Please contact your auto insurance company and provide the following:

- Personal injury protection maximum dollar amount
- Excess medical benefits maximum dollar amount
- Complete itemized statement indicating provider of service, date of service and to whom paid.

Section 4

**Is patient entitled to benefits from any other group insurance for hospital, surgical, medical or dental expenses?**  Yes  No

If yes, complete the following:

Name of other insurance carrier \_\_\_\_\_

Address of other insurance carrier \_\_\_\_\_

Certificate or policy number \_\_\_\_\_

Effective Date \_\_\_\_\_ Cancellation Date \_\_\_\_\_

Name of family member in whose name the policy is carried \_\_\_\_\_

Name of employer of family member named above \_\_\_\_\_

Section 5

**Is patient entitled to benefits under Medicare Hospital Insurance (Part A) or Medicare Medical Insurance (Part B)?**  Yes  No

If yes, complete the following:

Effective Date \_\_\_\_\_

Name \_\_\_\_\_

Section 6

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

**Signature of Alt. Payee** \_\_\_\_\_

**Date** \_\_\_\_/\_\_\_\_/\_\_\_\_

If you have questions regarding this form, call:

Blue Cross and Blue Shield of Kansas  
(785) 291-4180  
Toll free: 1-800-432-3990

State of Kansas Employees  
(785) 291-4185  
Toll free: 1-800-332-0307

To order additional forms, call Teleorder toll free at 1-800-346-2227, in Topeka at (785) 291-8130, or visit our Web site at [www.bcbsks.com](http://www.bcbsks.com)  
Please request form #34-438 12/08