

# STATE OF KANSAS CLAIM FORM



1133 S.W. Topeka Boulevard  
Topeka, Kansas 66629-0001

For status of claim information visit our website - [www.bcbsks.com](http://www.bcbsks.com)

**To be completed by insured. Be sure to attach itemized invoices from provider and complete itemizations starting on page 3. Bills will not be returned.**

1. Member's Name \_\_\_\_\_  
Last First Middle Initial

Group Number \_\_\_\_\_ Identification Number \_\_\_\_\_

2. Home Address \_\_\_\_\_  
Street

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone No. \_\_\_\_\_

If this is a new address, please check here

3. Was any treatment the result of ACCIDENTAL injury?  Yes  No **If yes, complete (a) and (b).**

(a) Was this the result of a motor vehicle or motorcycle accident?  Yes  No If yes, please provide your agent's name, address and telephone number. \_\_\_\_\_

(b) If treatment to any patient was the result of an accident, give the name of the patient(s) and date(s) of accident.

Name of Patient	Nature of Accident	Date of Accident		
		Month	Day	Year

4. Was any illness or injury work related?  Yes  No **If yes, complete the following.**

Name of Patient	Name of Employer	Employer Address

5. Is any patient covered under any other group health insurance plan? Yes  No  If Yes.

Policy holder's Name \_\_\_\_\_ Policy Number \_\_\_\_\_

Patient's Name \_\_\_\_\_

Insurance Company \_\_\_\_\_

Address of Company \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

NOTE: If your other Insurance Company has processed your claim, please attach their Explanation of Benefits to this claim form in addition to any itemized bills you may have from the provider.

6. Is any patient entitled to benefits under Medicare Hospital Insurance (Part A)? Yes  No

If yes, Effective date is   /  /   ID # \_\_\_\_\_ Name \_\_\_\_\_  
MO. DAY YR.

Is any patient entitled to benefits under Medicare Medical Insurance (Part B)? Yes  No  If yes,

Effective date is   /  /   ID # \_\_\_\_\_ Name \_\_\_\_\_  
MO. DAY YR.

I certify the information on this form is correct and that I am claiming benefits only for charges incurred by the patient(s) ITEMIZED on this form.

**X** \_\_\_\_\_  
 Signature of Member Date

# Instructions for completion of the "Summary of Itemized Bills"

**In order to ensure fast and accurate processing of your Major Medical claim and help hold down health care costs, please make sure the itemization is complete and accurate. See the illustration.**

1. List each patient separately:
  - a. Patient's full name
  - b. Month, day and year of birth
  - c. Relationship of patient to insured

2. List all services individually
  - a. Be specific with description of services
  - b. Be sure to include drug name and strength
  - c. Give National Drug Code No.

3. Make sure the service date listed is the actual date you received treatment and not the billing date, payment date, or receipt date.

4. Invoices or individual bills must be included for each service submitted. Itemized bills for prescriptions should include drug name, National Drug Code (NDC #), quantity and days supply. (cash register receipts, balances on accounts or cancelled checks are not acceptable)

5. List only those services for which you are requesting reimbursement.

6. If services are due to an accident, be sure to indicate the accident date and nature of accident beside each service involved.

7. 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.

8. Special instructions for Medicare Patients - When the patient is covered under Medicare Hospital Insurance (Part A), the "Notice of Health Insurance Utilization" form (or a copy of the form) pertaining to charges you are now claiming, must be enclosed with this claim form. When the patient is covered under Medicare Medical Insurance (Part B), the "Explanation of Medicare Benefits" form (or a copy of the form), pertaining to charges you are now claiming, must be enclosed with this form.

9. Send this completed form, together with itemized bills and supporting materials to:

Blue Cross and Blue Shield of Kansas

1133 S.W. Topeka Boulevard - Topeka, Kansas 66629-0001

(Additional claim forms can be obtained by contacting the Blue Cross and Blue Shield office in your area or from our Web site [www.bcbsks.com](http://www.bcbsks.com).)

SUMMARY OF ITEMIZED BILLS							
You <u>must</u> itemize your expenses for each patient separately. All itemized bills must be attached. Completion of this section is a requirement for filing and will speed the processing of your claim.							
Identification Number	Patient Name (First) (MI) (Last)			Birth Date (Mo/Day/Yr)	Relationship (Self, Spouse, Son, Daughter, other)		
1 2 3 4 5 6 7 8 9	Susan B. Hadley			8-10-59	Spouse		
Prescription Drugs							
Name of Pharmacy	Date Filled	RX Number	Quantity	Days Supply	Drug Name and Strength	National Drug Code (NDC)	Total Charge
Stanley Rexal	2-1-08	1234	45	15	Inderal 5 mg	00046-0473-76	\$57.13
Stanley Rexal	3-2-08	5678	100	69	Tagamet 200 mg	00108-5012-01	\$43.49
Medical Pharmacy	4-1-08	4150	50	120	Midrin	00086-0120-41	\$11.00
Revco	5-13-08	6513	250	125	Percocet	00060-0127-40	\$73.69
Super D Drug	6-2-08	7854	30	30	Zantac 150 mg	00173-0344-01	\$24.92
Services other than Prescription Drugs							
Name of Physician, Hospital, or other Provider of Services	Description of Services		Date of Service (Month/Day/Year)	Amount of Charge			
Dr. Smith	office Call		7-1-08	\$25.00			
Dr. Smith	Blood Culture		7-1-08	\$11.00			
Dr. Warner	X-ray Hand + Wrist		8-1-08	\$15.00			
Dr. Warner	Accident 8-1-08 office Call		8-1-08	\$20.00			

## Summary of itemized bills

You **must** itemize your expenses for each patient separately. All itemized bills **must** be attached. **Completion of this section is a requirement for filing** and will speed the processing of your claim.

Identification Number	Patient Name (First) <span style="margin-left: 100px;">(MI)</span> <span style="margin-left: 100px;">(Last)</span>	Birth Date Mo/Day/Yr	Relationship (Self, Spouse, Son, Daughter, other)

### Prescription Drugs

Name of Pharmacy	Date Filled	RX Number	Quantity	Days Supply	Drug Name and Strength	National Drug Code (NDC)	Total Charge

### Services other than Prescription Drugs

Name of Physician, Hospital, or other Provider of Services	Description of Services	Date of Service Month/Day/Year	Amount of Charge

## Summary of itemized bills

You **must** itemize your expenses for each patient separately. All itemized bills **must** be attached. **Completion of this section is a requirement for filing** and will speed the processing of your claim.

Identification Number	Patient Name (First) <span style="margin-left: 150px;">(MI)</span> <span style="margin-left: 50px;">(Last)</span>	Birth Date Mo/Day/Yr	Relationship (Self, Spouse, Son, Daughter, other)

### Prescription Drugs

Name of Pharmacy	Date Filled	RX Number	Quantity	Days Supply	Drug Name and Strength	National Drug Code (NDC)	Total Charge

### Services other than Prescription Drugs

Name of Physician, Hospital, or other Provider of Services	Description of Services	Date of Service Month/Day/Year	Amount of Charge