

Claim Form



www.bcbsks.com

This form does not need to be completed if your services were provided by a contracting hospital, physician, or dentist. These contracting providers will file a claim on your behalf.

Section 1

Patient Name _____ Date of Birth _____
Last First MI MM/DD/YYYY

Identification No. _____ Group No. _____

Home Address _____
Street

City State ZIP Code + 4

Home Phone No. _____ Cell Phone No. _____
Area Code Area Code

Work Phone No. _____ Fax No. _____
Area Code Area Code

E-mail Address _____

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

Section 2

Alternate Payee Information: Please complete this section if someone other than the cardholder is to be reimbursed.

Alt. Payee Name _____
Last First MI

Alt. Payee Address _____
Street

City State ZIP Code + 4

Alt. Home Phone No. _____ Alt. Cell Phone No. _____
Area Code Area Code

Alt. Work Phone No. _____ Alt. Fax No. _____
Area Code Area Code

Alt. E-mail Address _____

Section 3

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 _____

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

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

Section 4

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

Type of motor vehicle involved _____

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

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.

Please continue on other side. →

Is patient entitled to benefits from any other group health insurance? 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 _____

Is this patient entitled to benefits under Medicare hospital insurance (Part A)? Yes No

If yes, effective date is _____ ID# _____
MM/DD/YYYY

Name on Card _____

Is this patient entitled to benefits under Medicare medical insurance (Part B)? Yes No

If yes, effective date is _____ ID# _____
MM/DD/YYYY

Name on Card _____

Is this patient entitled to benefits under Medicare prescription drug insurance (Part D)? Yes No

If yes, effective date is _____ ID# _____
MM/DD/YYYY

Name on Card _____

For prescription drug claims: File one claim per patient and attach an itemized bill from the pharmacy with the pharmacist's signature or the pharmacy receipts. Do not send cash register receipts. The proof of service must include patient's name, prescription name and prescription Rx number, NDC code, quantity, number of days supply, service date, cost for each prescription plus the complete name and address of the pharmacy, and the pharmacy tax ID number.

For all other services: File one claim per patient and attach an itemized bill from the service provider. The itemization must include the patient's name, the service provided, service date, cost for each service, diagnosis, and the provider's name and tax ID number. Please complete a separate claim form in full for each hospital and/or doctor bill being submitted.

Prompt filing of claims: Notice of your claim must reach Blue Cross and Blue Shield of Kansas within one (1) year and ninety (90) days from the date services were received. **Submit this claim to:**

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

I represent that 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

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