

Hospital Indemnity Plan Claim Form

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



Section 1 – Member Information (as it appears on your BCBSKS identification card)

First Name _____ MI _____ Date of Birth _____
Last Name _____ Suffix _____ Member ID Number _____
Street Address _____ Group Number _____
City _____ Is the above a change of address? Yes No
State _____ ZIP Code _____ +4 _____

Section 2 – Patient Information

First Name _____ MI _____ Nature of illness: _____
Last Name _____ Suffix _____
Street Address _____
City _____ Diagnosis: _____
State _____ ZIP Code _____ +4 _____
Gender Male Female Date of Birth _____
Relationship to Member: Self Spouse
 Child Other
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 this claim the result of an accidental injury? Yes No
If yes, give date of accident: _____ Date of Accident _____
Please give 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

Please continue on the next page.

Section 3 – Report of Services (continued)

Were any of these hospital stays in a skilled nursing or rehabilitation hospital? Yes No

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

Acupuncture? Yes No Dental care? Yes No

Sexual misfunctions? Yes No Convalescent care? Yes No

Nervous and mental conditions? Yes No

For contract purposes, has the patient received evaluation, treatment, prescription refills, or any medical treatment in the last year (365 days) by any provider? Yes No

If yes, please indicate dates, diagnosis and provider information below:

Date of occurrence(s)	Diagnosis	Performing/Prescribing Provider Name and Address

Section 4 – 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

Section 5 – 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

material fact, such omission or misrepresentation may result in the re-rating, termination or rescission of my health care coverage and/or criminal prosecution.

Your signature required

 Applicant (Signature of parent/guardian if other than applicant)

 Date Signed

 Print Name

This information is being furnished in compliance with applicable federal regulations.

This Notice has important information. This notice has important information about your application or coverage through Blue Cross and Blue Shield of Kansas. Look for key dates in this notice. You may need to take action by certain deadlines to keep your health coverage or help with costs. You have the right to get this information and help in your language at no cost. Please call 1-800-432-3990.

Discrimination is against the law.

Blue Cross and Blue Shield of Kansas (BCBSKS) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. BCBSKS does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Blue Cross and Blue Shield of Kansas:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact Holly Graves.

If you believe that BCBSKS has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Holly Graves, Director, Individual Sales and Customer Service, 1133 S.W. Topeka Blvd., Topeka, KS 66629-0001, 1-800-432-3990, TTY: 1-800-766-3777, Fax: 785-290-0711, CSC@bcbsks.com.

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Holly Graves is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

Para obtener asistencia en español, llame al servicio de atención al cliente al número que aparece en su tarjeta de identificación.

請撥打您 ID 卡上的客服號碼以尋求中文協助。

Gọi số dịch vụ khách hàng trên thẻ ID của quý vị để được hỗ trợ bằng Tiếng Việt.

한국어로 도움을 받고 싶으시면 ID 카드에 있는 고객 서비스 전화번호로 문의해 주십시오.

Para sa tulong sa Tagalog, tumawag sa numero ng serbisyo sa customer na nasa inyong ID card.

Обратитесь по номеру телефона обслуживания клиентов, указанному на Вашей идентификационной карточке, для помощи на русском языке.

اتصل برقم خدمة العملاء الموجود على بطاقة هويتك للحصول على المساعدة باللغة العربية.

Rele nimewo sèvis kliyantèl ki nan kat ID ou pou jwenn èd nan Kreyòl Ayisyen.

Pour une assistance en français du Canada, composez le numéro de téléphone du service à la clientèle figurant sur votre carte d'identification.

Ligue para o número de telefone de atendimento ao cliente exibido no seu cartão de identificação para obter ajuda em português.

Aby uzyskać pomoc w języku polskim, należy zadzwonić do działu obsługi klienta pod numer podany na identyfikatorze.

日本語でのサポートは、ID カードに記載のカスタマーサービス番号までお電話でお問い合わせください。

Per assistenza in italiano chiamate il numero del servizio clienti riportato nella vostra scheda identificativa.

Rufen Sie den Kundendienst unter der Nummer auf Ihrer ID-Karte an, um Hilfestellung in deutscher Sprache zu erhalten.

برای دریافت راهنمایی به زبان فارسی ، با شماره خدمات مشتری که بر روی کارت شناسایی شما درج شده است تماس بگیرید..