# Cancer Plan Claim Form

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

BlueCross BlueShield of Kansas

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

CLEAR FORM

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 – Type of Claim

☐ Cancer treatment ☐ Wellness screening (Secure 300 members only)

## Section 3 – Patient Information

First Name _____ MI _____

Last Name _____ Suffix _____

Street Address _____

City _____

State _____ ZIP Code _____ +4 _____

Gender ☐ Male ☐ Female _____ / _____ / _____ Date of Birth

Relationship to Member: ☐ Self ☐ Spouse ☐ Child ☐ Other

Please give date of service on bills submitted:

_____ / _____ / _____ Earliest Date

_____ / _____ / _____ Last Date

Nature of illness:

Diagnosis:

## Section 4 – Diagnosing Physician Information

First Name _____ MI _____

Last Name _____ Suffix _____

Street Address _____

City _____

State _____ ZIP Code _____ +4 _____

(_____) _____-_____ Phone Number

**IMPORTANT:** If this is the first cancer claim, please submit the pathology report documenting the cancer diagnosis. If this is for inpatient services, please include the Admission and Discharge Summary.

**Please continue on the next page.**

## **Section 5** – Report of Services (attach itemized bill)

| Date of service | Description of surgical or medical services received |
|---|---|
| | |
| | |
| | |
| | |
| | |

## **Section 6** – General Information

**All claims forms MUST be submitted with itemized bill(s) except wellness screenings (see below).**
Cancelled checks, payment receipts, or balance forward bills are not acceptable substitutes for your itemized bill.

All claims MUST 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**
Attach your itemized hospital bill(s) and submit this claim form. A pathology report (documenting the cancer diagnosis) is required for claim processing.

**Payment for wellness screenings (Secure 300 only)**
Attach your itemized bill or Blue Cross and Blue Shield of Kansas Explanation of Benefit (showing the applicable wellness screening* completed) and submit this claim form to receive payment for your wellness screening.

*Applicable wellness screenings include: breast ultrasound, breast MRI, mammograms, CA 15-3 (blood test for breast cancer), pap smear, thinprep, biopsy, CEA (blood test for colon cancer), testicular ultrasound, thermography, flexible sigmoidoscopy, colonoscopy, virtual colonoscopy, hemoccult stool specimen.

**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 7** – 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.

I hereby authorize the diagnosing physician named above to release any information acquired in the course of my examination or treatment.

**Your signature required**

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

_____
Print Name