Claim Form

BlueCross BlueShield Kansas

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 Information

CLEAR DATA

First Name _____ MI _____

Last Name _____ Suffix _____

Residential Address _____

City _____

State _____ ZIP Code _____ +4 _____

BCBSKS Identification Number _____

Group Number _____

Date of Birth _____ / _____ / _____

Home Phone Number (_____) _____-_____

Cell Phone Number (_____) _____-_____

Email 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.

First Name _____ MI _____

Last Name _____ Suffix _____

Address _____

City _____

State _____ ZIP Code _____ +4 _____

Home Phone Number (_____) _____-_____

Cell Phone Number (_____) _____-_____

Email Address _____

Section 3 – Information About Your Injury or Illness

Is this service related to an accident? ☐ Yes ☐ No

If yes, please complete the following information:

_____ / _____ / _____
Date of Accident

How did the accident occur?

Accident occurred at: ☐ 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 – Motor Vehicle Injuries

Was the injury the result of physical contact with a motor vehicle? ☐ Yes ☐ No

If yes, please complete the following information:

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 the next page.

Section 5 – Other Group Health Insurance

Is the patient entitled to benefits from any other group health insurance? ☐ Yes ☐ No

If yes, please complete the following information:

Name of Other Insurance Carrier

Certificate or Policy Number

Residential Address

Effective Date _____ / _____ / _____

Cancellation Date _____ / _____ / _____

City

Name of family member in whose name the policy is carried

State ZIP Code +4

Name of employer of family member named above

Section 6 – Medicare Coverage

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

If yes, please complete the following information:

Effective Date _____ / _____ / _____

Medicare ID Number

Name on Medicare card

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

If yes, please complete the following information:

Effective Date _____ / _____ / _____

Medicare ID Number

Name on Medicare card

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

If yes, please complete the following information:

Effective Date _____ / _____ / _____

Medicare ID Number

Name on Medicare card

Section 7 – Additional Information and Authorization

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.

Please note: Additional information may be required to complete the processing of your claim.

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.

Your signature required

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

Date Signed _____ / _____ / _____

Print Name

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
(785) 291-8130
Toll free: 1-800-346-2227
or visit our website: bcbsks.com