



P.O. Box 1219
Newark, NJ 07105-1219

Horizon Blue Cross Blue Shield of New Jersey

NATIONAL ACCOUNTS HEALTH INSURANCE CLAIM FORM

PICA <input type="checkbox"/>		PICA <input type="checkbox"/>	
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/> <small>(Medicare #) (Medicaid #) (Sponsor's SSN) (Member ID#) (SSN or ID) (SSN) (ID)</small>		1a. INSURED'S I.D. NUMBER PREFIX (if any) NUMBER PORTION (For Program in Item 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
3. PATIENT'S BIRTH DATE MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street)	
5. PATIENT'S ADDRESS (No., Street)		6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	
CITY	STATE	CITY	STATE
ZIP CODE	TELEPHONE (Include Area Code)	ZIP CODE	TELEPHONE (Include Area Code)
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		11. INSURED'S POLICY GROUP OR FECA NUMBER	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>	
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>		b. EMPLOYER'S NAME OR SCHOOL NAME	
c. EMPLOYER'S NAME OR SCHOOL NAME		c. INSURANCE PLAN NAME OR PROGRAM NAME	
d. INSURANCE PLAN NAME OR PROGRAM NAME		10d. RESERVED FOR LOCAL USE	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____	
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY		15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.	
23. PRIOR AUTHORIZATION NUMBER		24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EPSDT Family Plan I. ID. QUAL J. RENDERING PROVIDER ID. #	
25. FEDERAL TAX I.D. NUMBER SSN EIN <input type="checkbox"/>		26. PATIENT'S ACCOUNT NO.	
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$	
29. AMOUNT PAID \$		30. BALANCE DUE \$	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)		32. SERVICE FACILITY LOCATION INFORMATION	
33. BILLING PROVIDER INFO & PH # ()			
SIGNED _____ DATE _____		a. NPI b. NPI	

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

PLEASE ATTACH COPY OF RECEIPT TO THIS FORM

PLEASE READ THIS IMPORTANT INFORMATION

COORDINATION OF BENEFITS?

If the spouse or the policyholder/patient is covered by another health insurance program, please provide the information requested in Section III.
 Example: Spouse covered by another insurance company or other Horizon Blue Cross Blue Shield of New Jersey, Inc. coverage.

When submitting charges for services or supplies that have been partially paid or declined by other group health insurance, attach a copy of the Notice of Payment or Explanation of Benefits from the other health care insurer **along with itemized bill(s)**.

MEDICARE?

If PATIENT is eligible for Medicare Benefits, be sure you include the Explanation of Medicare Benefits (EOMB) that was sent to patient explaining the charges paid or not paid by Medicare.

To process a claim for your Horizon Blue Cross Blue Shield of New Jersey, Inc., supplementary insurance, we need a copy of the Explanation of Medicare Benefits (EOMB). This EOMB should have been sent to you when Medicare processed your claim. If your EOMB has more than one page, send us copies of all pages. Please write your Horizon Blue Cross Blue Shield of New Jersey, Inc. identification number clearly on the first page.

CLAIM FORM WILL BE RETURNED TO YOU IF THIS ADDITIONAL INFORMATION IS NOT SUPPLIED

An example of an Explanation of Medicare Benefits (EOMB) is displayed below.

THIS IS NOT A BILL
Explanation of Your Medicare Part B Benefits

John Doe
 12 Floral Lane
 Garden City, NJ 08000-0000

Your Medicare number is: **123-45-6789A** Your provider accepted assignment

Summary of this notice dated XXXX XX, XXXX			
Total charges:	\$	37.00	
Total Medicare approved:	\$	33.23	
We paid your provider:	\$	6.70	
Your total responsibility:	\$	26.53	

Details about this notice (See the back for more information.)

BILL SUBMITTED BY:
 Mailing Address:

Dates	Services and Service Codes	Charges	Medicare Approved	See Notes Below
XXX XX, XXXX	John R. Jones, M.D. 01 Office/outpatient visit, est (99213)	\$ 37.00		

Notes:
 x The approved amount for this procedure is based on

IMPORTANT: If you have any questions about this notice, call. You will need this notice if you contact us. To appeal our decision, you must WRITE us before XXXXXXXXXXX XX, XXXX. See #2 on the Back.

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John Doe
 Your Medicare number is: **123-45-6789A**

More details about this notice

General Information About Medicare

If using a Telecommunications Device for the Deaf (TDD), please call X-XXX-XXX-XXXX for Medicare Part B information.
 Please note that Medicare now covers flu shots.
 Do not accept durable medical equipment without discussing the need for such equipment with your physician.
 If you have questions about this notice, you may write to us at the following address:
 Pennsylvania Blue Shield, P.O. Box XXXXXXXXXXXXXXXXXXXXXXXXXXXX, XX XXXXX-XXXX
 If you want to appeal our decision, please write to us at the following address to have this claim reviewed:
 Medicare P.O. Box XXXXXX-XXXX

Medicare approved	\$	33.23	The provider agreed to accept this amount. See #4 on the back.
Amount applied	\$	24.85	You have now met \$ 100.00 of your \$100.00 deductible for XXXX.
Amount less deductible	\$	8.38	Medicare pays 80% of this total.
Your 20%	\$	1.68	You pay 20% of the approved amount.
Amount after deductible and your 20%	\$	6.70	
Medicare owes	\$	6.70	
We are paying the provider	\$	6.70	

Of the approved amount	\$	33.23	
Less what Medicare owes	\$	6.70	
Your total responsibility	\$	26.53	The provider may bill you for this amount. If you have other insurance, the other insurance may pay this amount.

IMPORTANT: If you have any questions about this notice, call. You will need this notice if you contact us. To appeal our decision, you must WRITE us before XXXXXXXXXXX XX, XXXX. See #2 on the Back.

SAMPLE ONLY

HELPFUL HINTS

When you are submitting expenses for more than one family member, please use a separate claim form for each person.

It is suggested that you make copies for your own use before you submit the original bills.

Prescription Drugs? Bills must show the patient's name and date of service, prescription number and amount paid, name, strength & quantity of drug and the name and address of the pharmacy.

Durable medical equipment? (Wheel chair, crutches, braces, oxygen, etc.) Your doctor's certification must be submitted indicating the expected length of time the equipment will be in use. If renting, please have your medical equipment supplier also indicate the purchase price of the equipment on the bill.

Please mail completed claim form to: **Horizon Blue Cross Blue Shield of New Jersey**
 P.O. Box 1219
 Newark, New Jersey 07101-1219

FRAUD WARNING
 ANY PERSON WHO KNOWINGLY FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE OR MISLEADING INFORMATION IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES
 TO REPORT SUSPECTED FRAUD CALL 1-800-624-2048 AT HORIZON BLUE CROSS BLUE SHIELD OF NEW JERSEY, INC.