



**NEW JERSEY
STATE HEALTH BENEFITS PROGRAM**

Traditional Plan Claim Form

(PLEASE TYPE OR PRINT)

DO NOT WRITE ABOVE THIS LINE

I. MEMBER	1. MEMBER'S NAME (Last, First, Middle Initial)		2. MEMBER'S IDENTIFICATION NUMBER ALPHA-NUMERIC PORTION	
			PREFIX YHA	3HZN
3. MEMBER'S ADDRESS (No., Street)		CITY		STATE ZIP CODE
4. TELEPHONE NUMBER (Include Area Code) ()		5. MEMBER'S STATUS <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Widowed		5a. EMPLOYMENT STATUS <input type="checkbox"/> Active <input type="checkbox"/> COBRA <input type="checkbox"/> Retired
		5b. MEMBER'S BIRTH DATE Month Day Year		5c. MEMBER'S SEX <input type="checkbox"/> Male <input type="checkbox"/> Female
II. PATIENT	6. PATIENT'S NAME (Last, First, Middle Initial)		9. IS PATIENT'S CONDITION RELATED TO:	
	7. PATIENT'S BIRTH DATE Month Day Year		a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> NO <input type="checkbox"/> YES	
	7a. PATIENT'S SEX <input type="checkbox"/> Male <input type="checkbox"/> Female		b. AUTO ACCIDENT <input type="checkbox"/> NO <input type="checkbox"/> YES	
	8. PATIENT'S STATUS <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Widowed		c. OTHER ACCIDENT <input type="checkbox"/> NO <input type="checkbox"/> YES	
10. PATIENT'S RELATIONSHIP TO MEMBER <input type="checkbox"/> Self <input type="checkbox"/> Spouse/Domestic Partner <input type="checkbox"/> Child <input type="checkbox"/> Other		11. IS PATIENT EMPLOYED? <input type="checkbox"/> YES <input type="checkbox"/> NO		d. DATE OF ACCIDENT ____/____/____
		IF YES, LIST EMPLOYER: _____		STATE IN WHICH AUTO ACCIDENT OCCURRED: _____
III. COORDINATION OF BENEFITS	12. IS PATIENT COVERED BY ANOTHER GROUP HEALTH PLAN, HMO, MEDICAID OR ANY OTHER FEDERAL, STATE OR GOVERNMENTAL AGENCY? <input type="checkbox"/> YES <input type="checkbox"/> NO If Yes, Complete Questions 12a through 12h		12a. DOES THE PATIENT HAVE: MEDICARE PART A? <input type="checkbox"/> NO <input type="checkbox"/> YES EFFECTIVE DATE: _____ MEDICARE PART B? <input type="checkbox"/> NO <input type="checkbox"/> YES EFFECTIVE DATE: _____ REASON FOR ENTITLEMENT? <input type="checkbox"/> AGE <input type="checkbox"/> DISABILITY <input type="checkbox"/> ESRD	
	12b. OTHER POLICYHOLDER'S NAME		12c. OTHER POLICYHOLDER'S EMPLOYMENT STATUS <input type="checkbox"/> Active <input type="checkbox"/> COBRA <input type="checkbox"/> Retired	
	12e. OTHER HEALTH PLAN NAME		12d. OTHER POLICYHOLDER'S DATE OF BIRTH Month Day Year	
	12g. OTHER HEALTH PLAN ADDRESS (No., Street)		12f. OTHER HEALTH PLAN IDENTIFICATION NUMBER AND GROUP NUMBER	
			CITY STATE ZIP CODE	
			12h. COMPLETE IF YOU DO NOT HAVE MEDICARE COVERAGE AND IF YOU CHECKED ACTIVE OR COBRA IN SECTION 5a. IF YOU HAVE SINGLE COVERAGE ONLY, DID YOUR INCOME LAST YEAR (AS FILED ON IRS 1040 FORM) EXCEED \$14,000? <input type="checkbox"/> YES <input type="checkbox"/> NO IF "NO" PLEASE ATTACH COPY OF LAST YEAR'S IRS 1040 FORM. IF YOU ARE COVERING DEPENDENTS, DID YOUR FAMILY INCOME LAST YEAR (AS FILED ON IRS 1040 FORM) EXCEED \$20,000? <input type="checkbox"/> YES <input type="checkbox"/> NO IF "NO" PLEASE ATTACH COPY OF LAST YEAR'S IRS 1040 FORM.	
IV. AUTHORIZATION	13. THE FOLLOWING AUTHORIZATION TO RELEASE INFORMATION MUST BE COMPLETED: For claim adjudication, analysis, and administration, I agree that New Jersey State auditors, NJ State Health Benefits Program and Horizon Blue Cross Blue Shield of New Jersey may see, or get a copy of, ALL RECORDS which pertain to claims I submit or incur for myself or my covered dependents under the New Jersey State Health Benefits Traditional Plan. This information is for the sole use of New Jersey State to administer and analyze its health program, or Horizon Blue Cross Blue Shield of New Jersey, which will process the claim. Unless a law requires it, information will not be given in an identifiable form to any other persons unless I agree to its release in writing.			
			Signature of Patient (unless a minor) _____ Date _____	
V. SIGNATURE	14. I the undersigned, authorize and request Horizon Blue Cross Blue Shield of New Jersey, to make payment for benefits which may be due herein to:			
	NAME OF HEALTH CARE PROFESSIONAL AND THEIR TAX ID (REQUIRED) AND NPI NUMBER _____		MEMBER'S SIGNATURE _____ DATE _____	



PLEASE READ THIS IMPORTANT INFORMATION CAREFULLY

COORDINATION OF BENEFITS

If you or your dependent(s) are covered by another health insurance program, please complete the information requested in Section III.
Example: Spouse covered by another insurance company or other Horizon Blue Cross Blue Shield of New Jersey coverage.

When submitting charges for services or supplies that have been partially paid or declined by other group health insurance, including claims related to auto accidents, 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 you or your dependent(s) are eligible for Medicare Benefits and Medicare is your primary insurer, be sure you include the Explanation of Medicare Benefits (EOMB) that was sent by Medicare explaining the charges paid or not paid.

If your EOMB has more than one page, send us copies of all pages.

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

HELPFUL HINTS

When you are submitting expenses for more than one family member, please complete a separate claim form for each person. Itemized bills for covered services or supplies must be attached to the form and include the following:

Check that each itemized bill is legible and contains ALL of the following information:

- NAME & ADDRESS of Health Care Professional rendering the service or supplying the item
- HEALTH CARE PROFESSIONAL'S Federal Tax Identification Number (required) and NPI Number
- PATIENT'S FULL NAME
- TYPE of service rendered or item supplied
- DATE each service rendered or item supplied
- AMOUNT charged for each service rendered or item supplied
- DIAGNOSIS

**BILLS MISSING ANY OF
THIS INFORMATION WILL
DELAY PROCESSING AND
MAY BE RETURNED
TO YOU**

Cash register receipts, cancelled checks, money order receipts, personal itemizations, and bills only noting a "balance due" are not acceptable.

If you have any questions about how to submit your Claims, please call the Customer Service # 1-800-414-SHBP (7427).

Please make copies of your bills for your records before you submit the original bills.

Prescription Drugs Bills must show the prescription number, name 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.

Foreign Claim? Bills for services incurred outside of the U.S. must include an English translation and the exchange rate at the time of services.

WHERE TO SUBMIT YOUR CLAIM FORMS

**Horizon Blue Cross Blue Shield of New Jersey
P.O. Box 1609
Newark, New Jersey 07101-1609**

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
