INSTRUCTIONS TO SUBMIT A MAJOR MEDICAL CLAIM

When you have enough charges to satisfy your deductible, you may file a Major Medical claim! You DO NOT have to wait until the end of the year. In fact, you will probably get faster service if you send charges quarterly throughout the year. Details about your deductible can be found in your benefit booklet.
When you complete the attached Major Medical Claim Form, please follow the instructions carefully.

Unless every question is answered, we will return the form to you for the information. YOUR PAYMENT WILL THEN BE DELAYED.

1. Separate all bills for each family member. A separate claim form is needed for each person on your contract.
2. Bills must include:
   - ✓ Physician or pharmacist's signature
   - ✓ Provider's tax identification number or NPI
   - ✓ Name and address (on letterhead stationery) of person, store or other provider of service or supply (hospital, doctor, pharmacy, etc.).
   - ✓ Patient's full name.
   - ✓ Type of service or supply: Type of doctor's visit (brief, intermediate, extended, etc.), type of x-ray (leg, chest, etc.).
   - ✓ Date each service or supply was provided.
   - ✓ Doctor's diagnosis and/or patient's chief complaint for each service.
   - ✓ Amount charged for each service or supply. (See examples below.)

BILLS MISSING ANY OF THIS INFORMATION WILL BE RETURNED TO YOU

The following are **not** acceptable: cash register receipts, cancelled checks, money order receipts, personal lists. You must submit the original bills, receipts and forms. Please keep copies; bills cannot be returned.

3. **BILLS FOR THE FOLLOWING SERVICES SHOULD HAVE THIS ADDITIONAL INFORMATION.**

Prescription Drugs:. . . . . .Prescription number, name of drug, name of prescribing doctor.
Private Duty Nurse: . . . . . A Private Duty Nursing Certification Form must be submitted with each claim. Please contact our Claim and Benefit Service Division to obtain these forms. Please refer to your benefit card for the phone number.
Durable Medical Equipment: . . . . . Durable medical equipment must be certified as medically necessary by your physician on a Durable Medical Equipment Certification Form. Please contact our Claim and Benefit Service Division to obtain these forms. Please refer to your benefit card for the phone number.
(wheelchair, respirator, oxygen, etc.)
Blood Charges: . . . . . Include the number of pints received, charges for each, and the number of pints replaced by donors.

4. **STOP!** When sending bills, please circle only the services or supplies you are claiming. **If you have received any payment or rejection notices from CareFirst BlueCross BlueShield, Medicare or other insurance, please send them to us. These notices are usually called "Summary or Explanation of Benefits" sheets.**

PLEASE KEEP COPIES OF YOUR BILLS. SUBMITTED BILLS CANNOT BE RETURNED TO YOU.

EXAMPLES OF ACCEPTABLE BILLS TO BE SUBMITTED WITH THIS CLAIM FORM

PHYSICIAN BILL

ACCEPTABLE

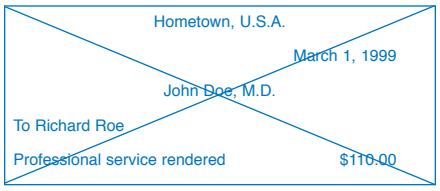
John Doe, M.D.
456 Main Street
Hometown, U.S.A.

March 1, 1999

To Richard Roe

2/01/99 Extended Office Visit – Cold	$ 35.00
2/10/99 Consultation – Diabetes	$ 50.00
2/28/99 Brief Home Visit – Virus	$ 25.00
	$ 110.00

NOT ACCEPTABLE



Missing: Dates, types and levels of service, amount charged for each service, and diagnosis or chief complaint.

PRIVATE DUTY NURSING BILL

789 Main Street
Hometown, U.S.A.

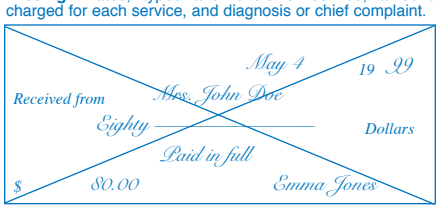
May 4, 1999

To Mrs. Robert Doe

Monday 2/7/99 8 AM - 12 AM	$40.00
Thursday 2/8/99 8 AM - 12 AM	$40.00
	$80.00

Service Prescribed by John Roe, M.D. 2/4/99
Emma Jones, RN Registration No. 27595

NOTE: Private duty nursing bills must be accompanied by a Private Duty Nursing Certification Form. See instructions above.



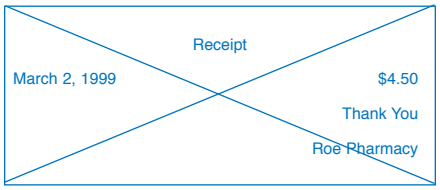
Missing: Dates and shifts worked, amount charged for each shift, the doctor's name, degree and registration number of nurse.

PRESCRIPTION DRUG BILL

Roe Pharmacy
100 Main Street
Hometown, U.S.A.

Drug Name . . . . . .March 2, 1999
Myra Doe,
RX 976-384 . . . . . .$4.50

Dr. John Smith



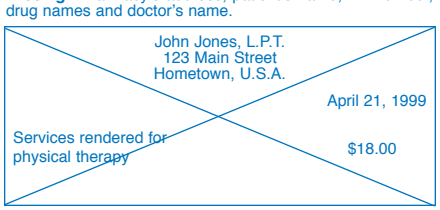
Missing: Pharmacy's address, patient's name, RX number, drug names and doctor's name.

LICENSED PHYSICAL THERAPIST

John Jones, L.P.T.
123 Main Street
Hometown, U.S.A.

April 21, 1999

Date of care: 3/10/99
Physical therapy office visit for Mechanical Traction $18.00
Diagnosis: Ruptured Disc
Patient: Terry Snow



Missing: Date of care, type of care, diagnosis, patient's name.

PLEASE READ:

The numbered items on this page thoroughly explain the matching questions on the facing page.

Read Section 1 of instructions and then complete Section 1 of the claim form etc. … please print or type

All questions must be answered or the claim will be returned.

1. SUBSCRIBER AND PATIENT INFORMATION:

The subscriber is the name that is on your CareFirst BlueCross BlueShield Membership card.
Copy your membership number from your membership card.
Fill in your present address and telephone number.
Copy your group number (example: X050 or 0442) from your membership card and fill in the name of your employer.
Complete the patient information fully, even if the subscriber and patient are the same person.

2. MEDICAL INFORMATION:

This section refers to injuries, conditions, diseases, or ailments that required the service and supplies shown on the bills you are submitting with this claim form. Please list the illness(es) and the date on which it first occurred.

FOR EXAMPLE:

ACCEPTABLE		NOT ACCEPTABLE	
A. Diabetes	1/1/11	A. Laboratory test	1/1/11
B. Asthma	3/25/11	B. See Attached	

3. ACCIDENTAL INJURY:

If this question does not apply to the attached bills, please check no. If yes, complete all questions.

4. WORK RELATED INJURY:

Check yes or no. DO NOT LEAVE BLANK.

5. MEDICARE:

These questions must be answered regardless of age. CHECK "YES" OR "NO". If yes, give effective date of Medicare entitlement (from Medicare Health Insurance card). Medicare is a federal health insurance program for people 65 or over and for certain disabled individuals.

6. OTHER HEALTH INSURANCE COVERAGE:

IF THE ANSWER IS YES, BE SURE TO COMPLETE ENTIRE SECTION. Please send itemized bills along with payment or rejection notices from the other insurance company. **This question must be answered or claim will be returned.**

7. AUTHORIZATION AND SIGNATURE:

Please read the authorization and sign the claim form. Forms without signatures will be returned.

When all the above items have been completed and checked, mail the claim form and itemized bills to:

Mail Administrator
P.O. Box 14115
Lexington, KY 40512-4115

TEAR OFF this sheet. Send us only the Major Medical claim form on opposite page and appropriate bills.

Mail Administrator
P.O. Box 14115
Lexington, KY 40512-4115

CareFirst

MAJOR MEDICAL CLAIM

1.

Subscriber's Legal Name (Last, First, Middle Initial)	Patient's Legal Name (Last, First, Middle Initial)
Membership Number (Including Alpha Prefix)	Patient's Sex ☐ Male ☐ Female — Patient's Relationship to Subscriber 1 ☐ Self 2 ☐ Spouse 3 ☐ Child
Subscriber's Address (Street) ☐ Check box if NEW address	Patient's Date of Birth MO. DAY YR.
City State Zip Code	
Telephone Number	
Group Number and Name	

IMPORTANT: ALL QUESTIONS MUST BE ANSWERED

2. List those illnesses for which you are submitting bills and date of first symptom.

_____ Date _____ Date

_____ Date _____ Date

3. Was the treatment the result of an accidental injury? ☐ Yes ☐ No

Description of Accident _____

Date of Accident _____ Where Accident Occurred _____

4. Was illness(es) or injury(ies) in any way work related? ☐ Yes ☐ No

5. Does patient have Medicare?

a. Medicare Part A (Hospital Insurance)? ☐ Yes ☐ No

b. Medicare Part B (Physician's Coverage)? ☐ Yes ☐ No

Effective Date of Coverage
_____ / _____ / _____ Month Day Year
_____ / _____ / _____ Month Day Year

HEALTH INSURANCE CLAIM NUMBER
_____

6. In addition to coverage under this program, is patient covered under any other insurance providing health care benefits or services?

☐ Yes ☐ No If "YES", please complete:

a. Name of Policy Holder _____ Relationship to Patient _____

b. Name of Insuring Co. _____

c. Policy or Certificate No. _____ d. Effective Date of Coverage _____ / _____ / _____ Month Day Year

e. Check type of coverage: ☐ Hospital ☐ Surgical-Medical ☐ Major Medical ☐ Other (specify) _____

f. Check One: I have ☐ Family ☐ Husband and Wife ☐ Individual ☐ Parent and Child coverage with this carrier.

g. Name and Address of Policy Holder's Employer _____

7. **I certify the above is complete and correct and that I am claiming benefits only for charges incurred by the patient named above. Authorization is hereby given to any hospital, physician, or other provider which participated in any way in my care and treatment to release to the CareFirst BlueCross BlueShield Plan any medical information which they in their judgment deem necessary to the adjudication of this claim.**

Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

X _____
SIGNATURE OF SUBSCRIBER DATE