State and Public School Employees' Health Insurance Plans

MEDICAL CLAIM FORM

• • • IMPORTANT: PLEASE READ THE INSTRUCTIONS ON THE BACK OF THIS FORM • • •

• • Your Physician does not need to sign this form • •

Please complete and sign a separate form for each patient

PATIENT INFORMATION

1. Patient's Name (No nicknames please)

First ______ MI ______ Last ______

3. Patient's Date of Birth

____ / ____ / ____
Month Day Year

4. Identification Number as Shown on I.D. Card

2. Name as Shown on I.D. Card

First ______ MI ______ Last ______

5. Patient's Sex

☐ Male ☐ Female

6. Patient's Relationship to Employee

☐ Self ☐ Child ☐ Spouse ☐ Other

7. Current Mailing Address

Street ______ City ______ State ______ Zip ______

Current Telephone Numbers: Home ______ Area Code ______ Office (optional) ______ Area Code ______

Payments and Explanation of Benefits will be sent to the most current address listed in our files. If your address changes, you must contact our Membership Services Department.

OTHER HEALTH INSURANCE INFORMATION

8. Is patient covered under any other health insurance plan? ☐ Yes ☐ No

If yes, complete the following: Name of Policyholder ______ Last ______ First ______ Middle

Name of Employer (if group coverage) ______

Name and Address of Insuring Company ______ Name ______ Street ______ City ______ State ______ Zip

Policy # ______

9. Is patient covered under Medicare Part A (hospital) or Medicare Part B (medical):

Medicare Part A ☐ Yes ☐ No Effective Date ____ / ____ / ____ (Month Day Year)

Medicare Part B ☐ Yes ☐ No Effective Date ____ / ____ / ____ (Month Day Year)

Medicare Identification # ______

Is employee still actively employed?

☐ Yes ☐ No

If no, please enter effective date of retirement/ termination. ____ / ____ / ____ (Month Day Year)

CONDITION AND TREATMENT

10. Was condition related to:

Employment ☐ Auto Accident ☐ Other Accident/Injury ☐ Illness ☐

11. If Accident/Injury, give date.

____ / ____ / ____
Month Day Year

12. Describe the nature of accident or illness and list symptoms.

AUTHORIZATION

I certify that the information I have given is accurate to the best of my knowledge and that I am claiming benefits only for the charges incurred by the patient identified above. I authorize the release of any medical information necessary to process this claim.

Signature ______ Date ______

WHEN SHOULD YOU USE THIS FORM?

This form is designed to help you file itemized medical bills for you or an enrolled family member. You should not submit this form if your Health Care Provider has filed a claim for you. Retain your receipt for your records.

PLEASE REVIEW YOUR MEDICAL BILLS AND FILE CLAIMS AT LEAST ONCE A MONTH TO ENSURE THE TIMELY PROCESSING OF YOUR CLAIMS.

CLAIMS FILING INSTRUCTIONS

1 Gather All Your **Itemized Medical Bills**

2 Separate Your Bills For Each Family Member

3 Complete a Separate Claim Form For Each Family Member

- Attach **Itemized Medical Bills** for the patient named on the form. Each itemized bill must include the patient's name; the health care provider's name and address; the date of each service; descriptions and charge for each service.
- If you are covered under any other health insurance or under Medicare, you must attach a copy of the Explanation of Benefits indicating their payment.

DID YOU

**** USE A SEPARATE CLAIM FORM FOR EACH FAMILY MEMBER?

**** COMPLETE EACH SECTION OF THE CLAIM FORM ENTIRELY?

**** COPY YOUR IDENTIFICATION NUMBER DIRECTLY FROM YOUR ID CARD?

**** ATTACH THE ORIGINAL ITEMIZED BILL(S) FROM THE PROVIDER THAT DESCRIBES ALL SERVICES RENDERED AND INCLUDES DATES OF SERVICE AND CHARGES?

**** KEEP A COPY FOR YOUR RECORDS?

Please forward your completed form to:

Blue Cross & Blue Shield of Mississippi
P. O. Box 23071
Jackson, Mississippi 39225-3071

For further information or additional copies of this form, please contact our Customer Service Department. (1-800-709-7881)

Claims Administered by:

BlueCross BlueShield of Mississippi

BCBS 13007 11/97

Blue Cross & Blue Shield of Mississippi, A Mutual Insurance Company, is an independent licensee of the Blue Cross and Blue Shield Association.