Blue Cross Blue Shield of Kansas City

MEMBER REIMBURSEMENT CLAIM FORM

(PLEASE PRINT OR TYPE)

(See Instructions on Reverse Side Before Completing This Form)

1. PATIENT'S NAME (FIRST, M.I., LAST)	2. PATIENT'S DATE OF BIRTH MONTH DAY YEAR	3. PATIENT'S SEX MALE ☐ FEMALE ☐	4. PATIENT'S RELATIONSHIP TO MEMBER SELF ☐ SPOUSE ☐ CHILD ☐

5. IS ILLNESS OR INJURY CONNECTED TO PATIENT'S EMPLOYMENT? ☐ YES ☐ NO	6. IS CLAIM DUE TO ACCIDENT? ☐ YES ☐ NO	7. MEMBER ID (Include 3-digit Alpha Prefix)	8. GROUP NUMBER

9. AUTO ACCIDENT? ☐ YES ☐ NO	10. DATE OF ACCIDENT (If Services Related to Accident) Month Day Year	DATE OF ILLNESS (If Services Related to Illness) Month Day Year	Date of Last Menstrual Period (If Services Related to Pregnancy) Month Day Year

11. DOES PATIENT HAVE OTHER GROUP COVERAGE ☐ YES ☐ NO Name of Insurance Company _____ Identification Number _____ Group Number _____ Amount Paid by Other Insurance Co. (Attach Copy of Explanation of Benefits) _____	12. IS PATIENT ELIGIBLE FOR MEDICARE? ☐ YES ☐ NO Medicare Number _____ Amount Paid by Medicare (Attach Copy of Explanation of Medicare Benefits) _____

13. DESCRIBE THE ILLNESS OR INJURY FOR WHICH THE PATIENT RECEIVED TREATMENT	14. EMPLOYEE/POLICYHOLDER ADDRESS Box _____ Apt. No. _____ Street _____ City _____ State _____ Zip _____
15. EMPLOYEE/POLICYHOLDER'S NAME (First, M.I., Last)	

16. SIGNATURE OF EMPLOYEE/POLICYHOLDER NOTICE: Anyone who misrepresents or falsifies essential information to receive payment requested by this form may upon conviction be subject to fine and imprisonment under applicable laws. SIGNED (X) DATE	17. REFERRING PHYSICIAN	
	18. TOTAL CHARGES	19. PATIENT PAID AMOUNT

CLAIM INFORMATION (PLEASE ATTACH THE ITEMIZED BILL)

DO NOT WRITE IN THE SPACE BELOW — OFFICE USE ONLY

DATES OF SERVICE FROM	DATES OF SERVICE TO	PLACE OF SERVICE	TYPE OF SERVICE	PROCEDURE CODE	(EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)	DIAGNOSIS CODE	CHARGES	UNITS	CHARGE PER UNIT

20. PROVIDER NAME AND ADDRESS	PROVIDER I.D. NO.

COVID TESTING ONLY

1. Reason for testing:
   - ☐ Exposure or symptoms
   - ☐ Return to work / School / Daycare
   - ☐ Travel

2. Were you referred by a physician?
   - ☐ Yes
   - ☐ No

   If yes, please provide physician's name:

   _____

GENERAL INSTRUCTIONS FOR COMPLETING THIS CLAIM FORM

We want to process your claim promptly and accurately ... but we need your help to do so. Please read these instructions before completing the other side. This form should be used only when submitting a claim for the services of a non-participating health care provider from whom you have received services.

1. A separate claim form should be completed for each member of the family for whom expenses are being reported. The expenses on the claim should be for services from one provider and should be for dates of service in the same calendar year. Submit separate claims for each provider and each year.
2. An itemized bill must be attached to the claim form when you send it to us. The itemized bill ID.!.!£ show the patient's name, the provider name, the date each service was rendered, the type of each service, and charge for each service or supply. Pharmacy bills should also show the prescription number and the name of the drug. Cash register receipts, cancelled checks, or bills saying only "For Services Rendered" are not acceptable. THE BILLS MUST BE ITEMIZED. Since the bills will not be returned to you, you may want to make copies to attach to your copy of the claim form.
3. This is a two-part carbonless form, retain the yellow copy for your records. Submit the original along with the itemized statement(s) to the local Blue Cross Blue Shield office. If you are located in the Kansas City area send to Blue Cross and Blue Shield of Kansas City, PO Box 419169, Kansas City, MO 64141-6169. If you are located outside of the Kansas City area, please call the customer service phone number located on your ID card to obtain the address for the nearest BCBS office.
4. ADDITIONAL CLAIM FORMS ARE AVAILABLE from your group leader if your coverage is sponsored by your employer; otherwise, contact Customer Service (816) 395-2222.
5. Claims should be filed throughout the year as warranted by expenses, but must be filed within 365 days after the end of the calendar year in which the service is received.
6. Do not write in the areas designated for office use only.

YOUR GUIDE TO COMPLETING THIS FORM

Please Do Not Submit Claims For HMO, Preferred or Participating Providers

1. PATIENT'S NAME-Print first name, middle initial, last name. Example: Jane Q. Doe.
2. PATIENT'S BIRTHDATE-Show in numbers. Example 8/25/70.
3. PATIENT'S SEX-Check appropriate box.
4. PATIENT'S RELATIONSHIP TO SUBSCRIBER-Check appropriate box.
5. IS ILLNESS OR INJURY DUE TO PATIENT'S EMPLOYMENT-Check appropriate box.
6. IS CLAIM DUE TO ACCIDENT-Check appropriate box.
7. MEMBER ID NUMBER-Copy the number from your Blue Cross and Blue Shield membership card. Include the 3-digit alpha prefix.
8. GROUP NUMBER-Copy the number from your Blue Cross and Blue Shield membership card.
9. AUTO ACCIDENT-Check appropriate box.
10. DATE OF ACCIDENT-If services are related to an accident, show the date of the accident in numbers.
    DATE OF ILLNESS-If services are related to an illness, show the date the illness began.
    DATE OF LMP-If the services are related to pregnancy, show the date of the last menstrual period.
11. DOES PATIENT HAVE OTHER GROUP COVERAGE-Check appropriate box. If yes, print name of insurance company, identification number, group number and the amount paid by the other insuring agency.
12. IS THE PATIENT ELIGIBLE FOR MEDICARE-Check appropriate box. If yes, copy number from your Medicare Health Insurance card. Show the amount paid by Medicare and attach the Explanation of Medicare Benefits to this form when you submit your claim.
13. DESCRIBE THE ILLNESS OR INJURY-Identify each illness or injury for which this claim is being filed.

    Claims for payment of expenses related to accidents must not be combined with claims for payment of other illnesses.
14. EMPLOYEE/POLICYHOLDER ADDRESS-Show post office box number or apartment number if applicable, and street, city, state, and ZIP code.
15. EMPLOYEE/POLICYHOLDER-The name of the group employee or individual policyholder responsible for the membership.
16. SIGNATURE OF EMPLOYEE/POLICYHOLDER-The employee/policy holder (not the patient) must sign this claim form. Also include date claim form is signed.
17. REFERRING PHYSICIAN-If your physician referred you to this provider, please give the physician's name.
18. TOTAL CHARGES-Indicate the total amount of the charges on this bill. Be sure the itemized bill for all covered services is attached when you send us this claim form.
19. PATIENT PAID AMOUNT-If you have paid all or part of the bill, show the amount you have paid.

CLAIM INFORMATION-ATTACH YOUR ITEMIZED BILL TO THE CLAIM FORM

Please attach the itemized bill to the claim form when you submit it to us. Do not write in the area of the form designated for office use.

20. PROVIDER NAME AND ADDRESS-Show the name and address of the physician, hospital or other institution which provided the services.
    Do not submit claims for preferred or participating providers. They will submit all claims to us for you. Only one bill should be submitted for each provider on each claim form except for pharmacies. Pharmacy bills for accidents may be combined and submitted on one claim as "drugs-accident:• All other pharmacy bills may be combined and submitted as "drugs-illness."

    Note: Do not include expenses for drugs which can be purchased without a doctor's prescription, such as aspirin, even though your doctor may have prescribed them for you. Such drugs are not covered by this program.