



# INSTRUCTIONS

**THIS FORM IS TO BE USED TO SUBMIT A CLAIM FOR SERVICES UNDER YOUR HEALTH PLAN. TO AVOID HAVING YOUR CLAIM RETURNED:**

- ✓ PREPARE A **SEPARATE CLAIM FORM** FOR EACH FAMILY MEMBER.
- ✓ COMPLETE **ALL OF THE INFORMATION REQUESTED** IN ITEMS 1 THRU 18.
- ✓ IF YOU PREFER THAT **BENEFITS BE PAID TO THE PROVIDER OF SERVICE BE SURE TO COMPLETE THE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS ON THE FRONT.** CAREFIRST BLUECROSS BLUESHIELD RESERVES THE RIGHT TO MAKE PAYMENT DIRECTLY TO THE SUBSCRIBER AND TO REFUSE TO HONOR THE ASSIGNMENT OF ANY CLAIM TO ANY PERSON OR PARTY.

**EACH PROVIDER'S ORIGINAL ITEMIZED BILL MUST BE ATTACHED AND CONTAIN:**

- ✓ THE LETTERHEAD INDICATING THE NAME AND ADDRESS OF THE PERSON OR ORGANIZATION PROVIDING THE SERVICE
- ✓ THE DATE FOR EACH INDIVIDUAL SERVICE (A RANGE OF DATES CANNOT BE ACCEPTED)
- ✓ THE CHARGE FOR EACH INDIVIDUAL SERVICE
- ✓ A DESCRIPTION OF EACH SERVICE
- ✓ THE NAME OF THE PATIENT RECEIVING THE SERVICE

**ON EACH BILL, PLEASE CROSS OUT ANY CHARGES THAT WERE INCLUDED ON A PREVIOUS CLAIM. PERSONAL ITEMIZATIONS, CASH REGISTER RECEIPTS, CREDIT CARD RECEIPTS AND CANCELLED CHECKS ARE NOT ACCEPTABLE. ITEMIZED BILLS CANNOT BE RETURNED.**

**IN ADDITION TO THE ABOVE REQUIREMENTS, THE FOLLOWING INFORMATION WILL BE NEEDED:**

**ACCIDENTAL INJURY** - STATEMENTS MUST CONTAIN DETAILS AS TO WHEN, WHERE AND THE MANNER IN WHICH THE INJURY OCCURRED, AS WELL AS THE NAME AND ADDRESS OF THE PARTY AT FAULT.

**PRESCRIPTION DRUGS** - BILLS MUST INCLUDE THE PRESCRIPTION NUMBER, THE NAME OF THE DRUG AND THE NAME OF THE PHYSICIAN PRESCRIBING THE MEDICATION.

**PRIVATE DUTY NURSING** - BILLS MUST INCLUDE THE SHIFT WORKED, THE CHARGE PER HOUR, THE NUMBER OF HOURS WORKED, THE NURSE'S PROFESSIONAL STATUS, PROFESSIONAL LICENSE NUMBER AND FAMILY RELATIONSHIP TO THE PATIENT, IF ANY. A STATEMENT FROM THE ATTENDING PHYSICIAN MUST ACCOMPANY THE CLAIM. THE STATEMENT SHOULD EXPLAIN THE MEDICAL NECESSITY OF THE SERVICE AND THE AUTHORIZATION FOR IT.

**PROSTHETIC APPLIANCES AND THE RENTAL OR PURCHASE OF DURABLE MEDICAL EQUIPMENT** - A STATEMENT FROM THE ATTENDING PHYSICIAN MUST ACCOMPANY THE CLAIM. THE STATEMENT SHOULD EXPLAIN THE MEDICAL NECESSITY OF THE EQUIPMENT AND THE PHYSICIAN'S AUTHORIZATION FOR IT.

**PSYCHOTHERAPY** - BILLS MUST INCLUDE THE LENGTH OF THE SESSION, THE TYPE OF SESSION AND THE PROVIDER'S PROFESSIONAL STATUS. IF THE PROVIDER IS OTHER THAN A MEDICAL DOCTOR, THE PROVIDER'S PROFESSIONAL LICENSE NUMBER MUST ALSO BE GIVEN.

**FOR PATIENTS COVERED BY ANOTHER INSURANCE CARRIER OR MEDICARE** - IF THE PATIENT IS CLAIMING BENEFITS FOR ANY CHARGES THAT ARE ELIGIBLE FOR BENEFITS UNDER ANY OTHER HEALTH INSURANCE POLICY OR MEDICARE PART A AND/OR PART B, THE EXPLANATION OF BENEFITS FORM FURNISHED BY THE OTHER CARRIER PERTAINING TO THESE CHARGES MUST BE INCLUDED WITH THE ITEMIZED BILLS. A CLEAR PHOTOCOPY OF THE OTHER CARRIER'S EXPLANATION OF BENEFITS FORM IS ACCEPTABLE IN PLACE OF THE ORIGINAL DOCUMENT.

**BEFORE SUBMITTING YOUR CLAIM, PLEASE BE SURE THAT:**

1. THE CLAIM FORM IS FULLY COMPLETED AND SIGNED.
2. THE ITEMIZED BILLS ARE ATTACHED.
3. YOU HAVE KEPT COPIES OF EACH DOCUMENT AND BILL FOR YOUR PERSONAL RECORDS

**THE CLAIM FORM AND ALL RELATED MATERIALS SHOULD BE SUBMITTED TO:**

CAREFIRST BLUECROSS BLUESHIELD  
MAIL ADMINISTRATOR  
P.O. BOX 14116  
LEXINGTON, KY 40512-4116