MEDICAL CLAIM FORM
Claims Receipt Center
P.O. Box 211184
Eagan, MN 55121

TO BE COMPLETED BY PATIENT

PATIENT INFORMATION:

1. PATIENT'S NAME (LAST) (FIRST) (MIDDLE INITIAL)

2. PATIENT'S ADDRESS (STREET) (CITY) (STATE) (ZIP CODE)

3. MEMBER IDENTIFICATION NUMBER

4. PATIENT'S PHONE NUMBER ( ) AREA CODE

5. PATIENT'S BIRTH DATE MONTH | DAY | YEAR

6. PATIENT'S SEX ❑ MALE ❑ FEMALE

7. PATIENT'S RELATIONSHIP TO MEMBER ❑ SELF ❑ SPOUSE ❑ CHILD

8. DIAGNOSIS OR NATURE OF ILLNESS

9. WAS AN ACCIDENT INVOLVED? ❑ YES ❑ NO

IF YES WHEN? MONTH | DAY | YEAR

WHERE: ❑ AUTO ❑ WORK ❑ OTHER:

ENCLOSE A BRIEF DESCRIPTION OF HOW AND WHERE ACCIDENT OCCURRED

OTHER COVERAGE:

10. IS THE PATIENT COVERED BY ANY OTHER INSURANCE PLAN? ❑ YES ❑ NO

IF YES

NAME OF INSURANCE COMPANY

POLICY NUMBER

ADDRESS OF INSURANCE COMPANY

11. IS THE PATIENT ELIGIBLE FOR MEDICARE? ❑ YES ❑ NO

IF YES

MEDICARE PART A EFFECTIVE DATE MONTH ____/ DAY ____/ YEAR ____

MEDICARE PART B EFFECTIVE DATE MONTH ____/ DAY ____/ YEAR ____

PATIENT'S SIGNATURE:

1. Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. The signer agrees that any personally identifiable health information about the signer or signer's enrolled dependents is protected by the Health Insurance Portability and Accountability Act of 1996 and other privacy laws. In accordance with those laws, The Health Plan may use and disclose Protected Health Information for treatment, payment and health care operations as described in its Notice of Privacy Practices.

X PATIENT'S SIGNATURE:________________________________ **DATE:** __________

If your provider is in-network, the provider will submit a claim for you.
This claim form should be submitted only when you use a non-network provider who does not submit the claim for you.

Independence Blue Cross is an Independent Licensee of the Blue Cross and Blue Shield Association

PHYSICIAN OR SUPPLIER INFORMATION

1. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY – RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE NUMBER 1, 2, 3, ETC. OR DX CODE

1

2

3

4

2. A. DATE OF SERVICE FROM TO	B. PLACE OF SERVICE	C. FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN		D. DIAGNOSIS CODE	E. CHARGES	F. DAYS OR UNITS	G. LEAVE BLANK
		PROCEDURE CODE (IDENTIFY)	(EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)				

3. HAS FEE BEEN PAID? YES ☐ ☐ NO	4. TOTAL CHARGE	5. AMOUNT PAID	6. BALANCE DUE

7. PHYSICIAN'S OR ACCOUNT'S NAME, ADDRESS, ZIP CODE PROVIDER NO.

PLACE OF SERVICE CODES

1 — (IH) — Inpatient Hospital
2 — (OH) — Outpatient Hospital
3 — (O) — Doctor's Office
4 — (H) — Patient's Home
5 — — Day Care Facility (PSY)
6 — — Night Care Facility — (PSY)
7 — (NH) — Nursing Home
8 — (SNF) — Skilled Nursing Facility
9 — — Ambulance
0 — (OL) — Other Locations
A — (IL) — Independent Laboratory
B — — Other Medical Surgical Facility
C — (RTC) — Residential Treatment Center
D — (STF) — Specialized Treatment Facility

Language Assistance Services

Spanish: ATENCIÓN: Si habla español, cuenta con servicios de asistencia en idiomas disponibles de forma gratuita para usted. Llame al 1-800-275-2583 (TTY: 711).

Chinese: 注意：如果您讲中文，您可以得到免费的语言协助服务。致电 1-800-275-2583。

Korean: 안내사항: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-275-2583 번으로 전화하십시오.

Portuguese: ATENÇÃO: se você fala português, encontram-se disponíveis serviços gratuitos de assistência ao idioma. Ligue para 1-800-275-2583.

Gujarati: સૂચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. 1-800-275-2583 કૉલ કરો.

Vietnamese: LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi sẽ cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho bạn. Hãy gọi 1-800-275-2583.

Russian: ВНИМАНИЕ: Если вы говорите по-русски, то можете бесплатно воспользоваться услугами перевода. Тел.: 1-800-275-2583.

Polish UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-275-2583.

Italian: ATTENZIONE: Se lei parla italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-275-2583.

Arabic:
ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية متاحة لك بالمجان. اتصل برقم 1-800-275-2583.

French Creole: ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-275-2583.

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga serbisyo na tulong sa wika nang walang bayad. Tumawag sa 1-800-275-2583.

French: ATTENTION: Si vous parlez français, des services d'aide linguistique-vous sont proposés gratuitement. Appelez le 1-800-275-2583.

Pennsylvania Dutch: BASS UFF: Wann du Pennsylvania Deitsch schwetzscht, kannscht du Hilf griege in dei eegni Schprooch unni as es dich ennich eppes koschte zellt. Ruf die Nummer 1-800-275-2583.

Hindi: ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। कॉल करें 1-800-275-2583।

German: ACHTUNG: Wenn Sie Deutsch sprechen, können Sie kostenlos sprachliche Unterstützung anfordern. Wählen Sie 1-800-275-2583.

Japanese: 備考：母国語が日本語の方は、言語アシスタンスサービス（無料）をご利用いただけます。1-800-275-2583へお電話ください。

Persian (Farsi):
توجه: اگر فارسی صحبت می کنید، خدمات ترجمه به صورت رایگان برای شما فراهم می باشد. با شماره 1-800-275-2583 تماس بگیرید.

Navajo: Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dę́ę́', t'áá jiik'eh. Hódíílnih koji' 1-800-275-2583.

Urdu:
توجہ درکارہے: اگر آپ اردو زبان بولتے ہیں، تو آپ کے لئے مفت میں زبان معاون خدمات دستیاب ہیں۔ کال کریں 1-800-275-2583.

Mon-Khmer, Cambodian: ស្មមេត្តាចាប់អារម្មណ៍៖ ប្រសិនបើអ្នកនិយាយភាសាមន-ខ្មែរ ឬភាសាខ្មែរ នោះជំនួយផ្នែកភាសានឹងមានផ្តល់ជូនដល់លោកអ្នកដោយឥតគិតថ្លៃ។ ទូរសព្ទទៅលេខ 1-800-275-2583។

Discrimination is Against the Law

This Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. This Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

This Plan provides:

- Free aids and services to people with disabilities to communicate effectively with us, such as: qualified sign language interpreters, and written information in other formats (large print, audio, accessible electronic formats, other formats).
- Free language services to people whose primary language is not English, such as: qualified interpreters and information written in other languages.

If you need these services, contact our Civil Rights Coordinator. If you believe that This Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Civil Rights Coordinator. You can file a grievance in the following ways: In person or by mail: ATTN: Civil Rights Coordinator, 1901 Market Street, Philadelphia, PA 19103, By phone: 1-888-377-3933 (TTY: 711) By fax: 215-761-0245, By email: civilrightscoordinator@1901market.com. If you need help filing a grievance, our Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf* or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*.