



P.O. Box 1219 Newark, NJ 07101-1219

norizon blue Cross blue Snield of New Jersey		
(PLEASE TYPE OR PRINT)	National Accoun	nts Health Insurance Claim Form
1. MEDICARE MEDICAID CHAMPUS CHAMP		1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1) PREFIX (if any) NUMBER PORTION
(Medicare #) (Medicaid #) (Sponsor's SSN) (VA Fil	le #) HEALTH PLAN BLK LUNG (ID)	PREFIX (if any) NUMBER PORTION
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
	Self Spouse Child Other	THORES O ADDITES (No., Sheet)
CITY STAT	E 8. PATIENT STATUS	CITY STATE
ZIP CODE TELEPHONE (Include Area Code)	Single Married Other	ZIP CODE TELEPHONE (INCLUDE AREA CODE)
()	Employed Full-Time Part-Time Student	ZIP CODE TELEPHONE (INCLUDE AREA CODE) ()
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
OTHER MOURENO DOLLOY OR ORGAN MANAGER	- EMPLOYMENTS (CURRENT OR PREVIOUS)	
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO	a. INSURED'S DATE OF BIRTH MM DD YY M F F
b. OTHER INSURED'S DATE OF BIRTH SEX	b. AUTO ACCIDENT? PLACE (State)	b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT?	
C. EMPLOYER'S NAME OR SCHOOL NAME	TYES NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN?
		YES NO If yes, return to and complete item 9 a-d.
READ BACK OF FORM BEFORE COMPLETI 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize t to process this claim. I also request payment of government benefits eith below.	the release of any medical or other information necessary	INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED	DATE	SIGNED
14, DATE OF CURRENT: MM DD YY	5. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY MM DD YY FROM TO TO TO TO TO TO TO
	7a. I.D. NUMBER OF REFERRING PHYSICIAN	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO TO
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? \$ CHARGES
		YESNO
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEM	IS 1,2,3 OR 4 TO TIEM 24E BY LINE)	22. MEDICAID RESUBMISSION ORIGINAL REF. NO.
1	3	23. PRIOR AUTHORIZATION NUMBER
2	4	
24. A B C DATE(S) OF SERVICE Place Type PROCED	DURES, SERVICES, OR SUPPLIES DIAGNOSIS	F G H I J K DAYS EPSDT RESERVED FOR
From	plain Unusual Circumstances)	\$ CHARGES OR Family Plan EMG COB LOCAL USE
25. FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S	S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE 29. AMOUNT PAID 30. BALANCE DUE
	(For govt. claims, see back) YES NO	s s s
	D ADDRESS OF FACILITY WHERE SERVICES WERE ED (If other than home or office)	33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

PIN#

GRP#

PLEASE READ THIS IMPORTANT INFORMATION

COORDINATION OF BENEFITS?

If the spouse or the policyholder/patient is covered by another health insurance program, please provide the information requested in Section III. Example: Spouse covered by another insurance company or other Horizon Blue Cross Blue Shield of New Jersey, Inc. coverage.

When submitting charges for services or supplies that have been partially paid or declined by other group health insurance, attach a copy of the Notice of Payment or Explanation of Benefits from the other health care insurer along with itemized bill(s).

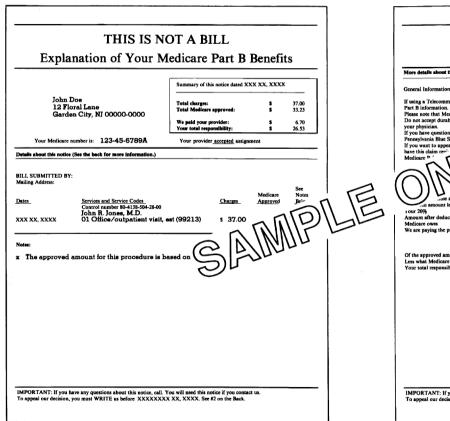
MEDICARE?

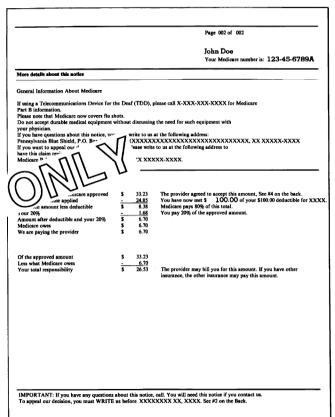
If PATIENT is eligible for Medicare Benefits, be sure you include the Explanation of Medicare Benefits (EOMB) that was sent to patient explaining the charges paid or not paid by Medicare.

To process a claim for your Horizon Blue Cross Blue Shield of New Jersey, Inc., supplementary insurance, we need a copy of the Explanation of Medicare Benefits (EOMB). This EOMB should have been sent to you when Medicare processed your claim. If your EOMB has more than one page, send us copies of all pages. Please write your Horizon Blue Cross Blue Shield of New Jersey, Inc. identification number clearly on the first page.

CLAIM FORM WILL BE RETURNED TO YOU IF THIS ADDITIONAL INFORMATION IS NOT SUPPLIED

An example of an Explanation of Medicare Benefits (EOMB) is displayed below.





HELPFUL HINTS

When you are submitting expenses for more than one family member, please use a separate claim form for each person.

It is suggested that you make copies for your own use before you submit the original bills.

Prescription Drugs? Bills must show the patient's name and date of service, prescription number and amount paid, name, strength & quantity of drug and the name and address of the pharmacy.

Durable medical equipment? (Wheel chair, crutches, braces, oxygen, etc.) Your doctor's certification must be submitted indicating the expected length of time the equipment will be in use. If renting, please have your medical equipment supplier also indicate the purchase price of the equipment on the bill.

Please mail completed claim form to:

Horizon Blue Cross Blue Shield of New Jersey P.O. Box 1219 Newark, New Jersey 07101-1219

FRAUD WARNING

ANY PERSON WHO KNOWINGLY FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE OR MISLEADING INFORMATION IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES