Horizon

Horizon Blue Cross Blue Shield of New Jersey

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

(PLEASE TYPE OR PRINT)

National Accounts Health Insurance Claim Form

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (VA File #) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)
PREFIX (if any) | NUMBER PORTION

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM | DD | YY SEX M ☐ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED
Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. PATIENT STATUS
Single ☐ Married ☐ Other ☐
Employed ☐ Full-Time Student ☐ Part-Time Student ☐

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

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

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) ☐ YES ☐ NO

a. INSURED'S DATE OF BIRTH MM | DD | YY SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM | DD | YY SEX M ☐ F ☐

b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? ☐ YES ☐ 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 COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM | DD | YY ◀ ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. 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 FROM MM | DD | YY TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM | DD | YY FROM MM | DD | YY TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)
1. ____ . __ 3. ____ . __
2. ____ . __ 4. ____ . __

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1												
2												
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☐ YES ☐ NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (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.

THIS IS NOT A BILL

Explanation of Your Medicare Part B Benefits

John Doe
12 Floral Lane
Garden City, NJ 00000-0000

Summary of this notice dated XXX XX, XXXX

Total charges:	$	37.00
Total Medicare approved:	$	33.23
We paid your provider:	$	6.70
Your total responsibility:	$	26.53

Your Medicare number is: 123-45-6789A Your provider accepted assignment

Details about this notice (See the back for more information.)

BILL SUBMITTED BY:
Mailing Address:

Dates	Services and Service Codes	Charges	Medicare Approved	See Notes Be-
	Control number 80-4138-504-28-00 John R. Jones, M.D.			
XXX XX, XXXX	01 Office/outpatient visit, est (99213)	$ 37.00		

Notes:

x The approved amount for this procedure is based on

IMPORTANT: If you have any questions about this notice, call. You will need this notice if you contact us.
To appeal our decision, you must WRITE us before XXXXXXXX XX, XXXX. See #2 on the Back.

SAMPLE ONLY

Page 002 of 002

John Doe
Your Medicare number is: 123-45-6789A

More details about this notice

General Information About Medicare

If using a Telecommunications Device for the Deaf (TDD), please call X-XXX-XXX-XXXX for Medicare Part B information.
Please note that Medicare now covers flu shots.
Do not accept durable medical equipment without discussing the need for such equipment with your physician.
If you have questions about this notice, w... write to us at the following address:
Pennsylvania Blue Shield, P.O. B... (XXXXXXXXXXXXXXXXXXXXXXXXXXXX, XX XXXXX-XXXX
If you want to appeal our ... lease write to us at the following address to have this claim re...
Medicare P... 'X XXXXX-XXXX.

...icare approved	$ 33.23	The provider agreed to accept this amount, See #4 on the back.
...ue applied	- 24.85	You have now met $ 100.00 of your $100.00 deductible for XXXX.
...d amount less deductible	$ 8.38	Medicare pays 80% of this total.
...our 20%	- 1.68	You pay 20% of the approved amount.
Amount after deductible and your 20%	$ 6.70	
Medicare owes	$ 6.70	
We are paying the provider	$ 6.70	
Of the approved amount	$ 33.23	
Less what Medicare owes	- 6.70	
Your total responsibility	$ 26.53	The provider may bill you for this amount. If you have other insurance, the other insurance may pay this amount.

IMPORTANT: If you have any questions about this notice, call. You will need this notice if you contact us.
To appeal our decision, you must WRITE us before XXXXXXXX XX, XXXX. See #2 on the Back.

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

TO REPORT SUSPECTED FRAUD CALL 1-800-624-2048 AT HORIZON BLUE CROSS BLUE SHIELD OF NEW JERSEY, INC.