

**HEALTH BENEFITS  
CLAIM FORM**



**BlueCross BlueShield  
of South Carolina**

An Independent Licensee of the  
Blue Cross and Blue Shield Association

Claims Processing Center  
P.O. Box 100300  
Columbia, SC 29202-3300

**1** **Employee's**  
Name \_\_\_\_\_  
Identification  
Number \_\_\_\_\_  
(Please include the letters if included on your ID Card)

**2** **Patient's**  
Name \_\_\_\_\_  
First Middle Initial Last

**3** The **Patient** is: Female  Male   
And Is The:     
Employee Employee's Spouse Employee's Child

**4** **Patient's** Month Day Year  
Date of Birth \_\_\_\_\_

**5** **Employee's**  Check If New Address  
Mailing Address \_\_\_\_\_  
Street City State ZIP Code

**6** Was any treatment required as a result of accidental injury?  Yes  No Date of accident \_\_\_\_\_

**7** If an accident, was another person at fault?  Yes  No If yes, please explain. \_\_\_\_\_

Was any injury or illness work related?  Yes  No

**8** Is the patient covered by Medicare Health Insurance, Part A?  Yes  No  
Or by Supplemental Medical Insurance, Part B?  Yes  No  
**If yes, please attach your "Explanation of Medicare Benefits." It is necessary to process your claim.**  
Complete the following Medicare Health Insurance Benefit Number # \_\_\_\_\_

Is the patient covered under any other health benefit plan?  Yes  No  
**If yes, please attach your "Explanation of Benefits" from the other Insurance Company.** Also, please complete this entire section as it is necessary to process this claim.

**9** A. Policyholder's Name \_\_\_\_\_  
Relationship of Policyholder to Patient \_\_\_\_\_  
B. Name of other Policyholder's Employer \_\_\_\_\_  
Address of other Policyholder's Employer \_\_\_\_\_  
City State ZIP Code  
C. Name of other Insurance Company \_\_\_\_\_  
Address of other Insurance Company \_\_\_\_\_

**CERTIFICATION OF MEMBER**

**10** I certify that the above information is correct and that the foregoing expenses were incurred for the above named patient. I request eligible benefits for these expenses. I authorize any physician, nurse, hospital or other provider or supplier in possession of records or information concerning the patient to furnish such information to Blue Cross and Blue Shield of South Carolina upon request. (Be sure to complete items 1-9 on this form and attach itemized statements for all expenses. **Absence of this information may cause a delay in processing this claim.**)

Date \_\_\_\_\_ Employee's Signature \_\_\_\_\_

**EXAMPLES OF  
PHYSICIANS, MEDICAL EQUIPMENT, PHARMACIST AND NURSING BILLS**

The following are properly filed itemized bills

**MEDICAL AND SURGICAL BILLS**

SHOULD INCLUDE THE FOLLOWING:

<p><b>(A)</b> Physician name and address.</p> <p><b>(B)</b> Full name of patient should appear on every bill, not just name of person paying bill.</p> <p><b>(C)</b> The date of surgery or medical treatment.</p> <p><b>(D)</b> The type of surgery performed or type of medical treatment.</p> <p><b>(E)</b> Separate cost for each treatment.</p>	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%;"><b>(A)</b> Harry Smith, M.D. Columbia, S.C.</td> <td style="width: 50%;"></td> </tr> <tr> <td><b>(B)</b> Patient John Jones</td> <td></td> </tr> <tr> <td><b>(C)</b> 9/18/96 9/17 - 23/96</td> <td><b>(D)</b> Surgery, Appendectomy Hospital Calls</td> </tr> <tr> <td><b>(C)</b> 10/23/96 12/1/96</td> <td><b>(D)</b> Office Call Office Call-Virus Injection</td> </tr> <tr> <td></td> <td><b>(E)</b> 250.00 No Charge No Charge 15.00 5.00</td> </tr> </table>	<b>(A)</b> Harry Smith, M.D. Columbia, S.C.		<b>(B)</b> Patient John Jones		<b>(C)</b> 9/18/96 9/17 - 23/96	<b>(D)</b> Surgery, Appendectomy Hospital Calls	<b>(C)</b> 10/23/96 12/1/96	<b>(D)</b> Office Call Office Call-Virus Injection		<b>(E)</b> 250.00 No Charge No Charge 15.00 5.00
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**MEDICAL EQUIPMENT**

SHOULD INCLUDE THE FOLLOWING:

<b>(A)</b> ACE-BRACE Co. Columbia, S.C.	
<b>(A)</b> Patient Nancy Smith	<b>(C)</b> Date 9/17/96
<b>(B)</b> Address 2905 Start Rd. Dr. Jones	<b>(B)</b> Phone 788-1234
<b>(D)</b> Quantity 1	<b>(D)</b> Rx Wheelchair - Economy
	<b>(D)</b> Price 299.00
	<b>(D)</b> TAX 11.96
	<b>(D)</b> 310.96

- (A)** Full name of patient.
  - (B)** Name of Doctor ordering Medical Equipment.
  - (C)** Date Medical Equipment purchased.
  - (D)** Description of equipment purchased.
- Note:-** Letter of medical necessity is required before major medical will process.

**DRUGGIST BILLS**

SHOULD INCLUDE THE FOLLOWING:

<p><b>(A)</b> Full name of patient. (Separate bill should be submitted for each member of family for whom major medical expense benefits are being claimed.)</p> <p><b>(B)</b> Date of purchase.</p> <p><b>(C)</b> Prescription number, quantity, name and strength of drug.</p> <p><b>(D)</b> Separate charge for each prescription.</p> <p><b>(E)</b> Pharmacist's signature.</p>	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td colspan="2"><b>(A)</b> PRICE PHARMACY 200 Market Street Columbia, S.C.</td> </tr> <tr> <td colspan="2">Patient: <b>(A)</b> Mary G. Jones</td> </tr> <tr> <td>Date</td> <td>Prescription Number Description Charge</td> </tr> <tr> <td><b>(B)</b> 8/31/96</td> <td><b>(C)</b> 575-516 60 Aldoril25mg Dr. G.S. Smith <b>(D)</b> 11.60</td> </tr> <tr> <td></td> <td>588-152 60 HCTZ50mg Dr. G.S. Smith 7.25</td> </tr> <tr> <td>10/1/96</td> <td>592-321 30 Aldoril25mg Dr. G.S. Smith 6.20</td> </tr> <tr> <td>12/9/96</td> <td>599-472 60 Aldoril25mg Dr. G.S. Smith 11.60</td> </tr> <tr> <td><b>(E)</b></td> <td><b>(E)</b> 36.65</td> </tr> </table>	<b>(A)</b> PRICE PHARMACY 200 Market Street Columbia, S.C.		Patient: <b>(A)</b> Mary G. Jones		Date	Prescription Number Description Charge	<b>(B)</b> 8/31/96	<b>(C)</b> 575-516 60 Aldoril25mg Dr. G.S. Smith <b>(D)</b> 11.60		588-152 60 HCTZ50mg Dr. G.S. Smith 7.25	10/1/96	592-321 30 Aldoril25mg Dr. G.S. Smith 6.20	12/9/96	599-472 60 Aldoril25mg Dr. G.S. Smith 11.60	<b>(E)</b>	<b>(E)</b> 36.65
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**NURSING BILLS**

SHOULD INCLUDE THE FOLLOWING:

<p><b>(A)</b> Nursing bills must clearly indicate whether the nurse is a Registered Nurse (RN) or Licensed Practical Nurse (LPN). Also the license or Registry Number.</p> <p><b>(B)</b> Name and address of patient.</p> <p><b>(C)</b> Were nursing services provided in Hospital, Home or Elsewhere?</p> <p><b>(D)</b> Dates worked.</p> <p><b>(E)</b> Shift and/or hours worked.</p>	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 30%;"><b>(A)</b> Nurse Diane Smith RN</td> <td style="width: 30%;"><b>(A)</b> LICENSE OR REGISTRY NO. 12345</td> <td style="width: 40%;"><b>(C)</b> PLACE OF TREATMENT Home Care</td> </tr> <tr> <td><b>(B)</b> FOR Mr. Ed Johnson</td> <td></td> <td></td> </tr> <tr> <td colspan="2"><b>(B)</b> ADDRESS 123 2nd St., Columbia, S.C.</td> <td></td> </tr> <tr> <td><b>(D)</b> 12/8/96</td> <td><b>(D)</b> DATES WORKED</td> <td><b>(D)</b> SHIFTS/HOURS</td> </tr> <tr> <td></td> <td></td> <td><b>(E)</b> 7-3 p.m./8 hrs.</td> </tr> <tr> <td>12/9/96</td> <td></td> <td>7-3 p.m./8 hrs.</td> </tr> <tr> <td>12/10/96</td> <td></td> <td>11-7 a.m./8 hrs</td> </tr> <tr> <td><b>(E)</b> TOTAL HOURS</td> <td></td> <td>24 hrs.</td> </tr> </table>	<b>(A)</b> Nurse Diane Smith RN	<b>(A)</b> LICENSE OR REGISTRY NO. 12345	<b>(C)</b> PLACE OF TREATMENT Home Care	<b>(B)</b> FOR Mr. Ed Johnson			<b>(B)</b> ADDRESS 123 2nd St., Columbia, S.C.			<b>(D)</b> 12/8/96	<b>(D)</b> DATES WORKED	<b>(D)</b> SHIFTS/HOURS			<b>(E)</b> 7-3 p.m./8 hrs.	12/9/96		7-3 p.m./8 hrs.	12/10/96		11-7 a.m./8 hrs	<b>(E)</b> TOTAL HOURS		24 hrs.
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