BlueCross BlueShield of Louisiana
An independent licensee of the Blue Cross and Blue Shield Association.

HEALTH INSURANCE CLAIM FORM

READ INSTRUCTIONS ON BACK BEFORE COMPLETING OR SIGNING THIS FORM

MAIL COMPLETED CLAIMS TO:

BLUE CROSS AND BLUE SHIELD
OF LOUISIANA
CLAIMS PROCESSING
P.O. BOX 98029
BATON ROUGE, LA 70898-9029

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

PLEASE PRINT OR TYPE **ONLY ONE PATIENT PER CLAIM FORM**

		1. SUBSCRIBER'S BLUE CROSS AND BLUE SHIELD CONTRACT NO.
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY SEX M ❑ F ❑	4. SUBSCRIBER'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (Street Number)	6. PATIENT RELATIONSHIP TO INSURED ❑ Self ❑ Spouse ❑ Child ❑ Other	7. SUBSCRIBER'S ADDRESS (Street Number)
CITY / STATE	8. IS THERE ANOTHER HEALTH BENEFIT PLAN? ❑ YES ❑ NO IF YES, COMPLETE ITEM 9.	CITY / STATE
ZIP CODE / TELEPHONE (Include Area Code) ( )		ZIP CODE / TELEPHONE (Include Area Code) ( ) ❑ CHECK IF THIS IS A NEW ADDRESS
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO	
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (CURRENT OR PREVIOUS) ❑ YES ❑ NO	11. SUBSCRIBER'S POLICY GROUP NO. OR GROUP NAME
b. OTHER HEALTH INSURANCE COVERAGE NAME AND ADDRESS	b. AUTO ACCIDENT? ❑ YES ❑ NO	a. SUBSCRIBER'S DATE OF BIRTH MM DD YY
	c. OTHER ACCIDENT OR INJURY? ❑ YES ❑ NO	b. SUBSCRIBER'S SEX M ❑ F ❑ RETIRED? ❑ YES ❑ NO
c. INSURANCE PLAN NAME OR PROGRAM NAME	d. DATE OF ACCIDENT OR INJURY?	c. INSURANCE PLAN NAME OR PROGRAM NAME

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURANCE COMPANY, FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION MAY BE GUILTY OF A CRIMINAL ACT PUNISHABLE UNDER LAW.

12. FOR OFFICE USE ONLY	**13. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICE DESCRIBED BELOW.** X PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE

PHYSICIAN OR SUPPLIER INFORMATION (ONLY ONE PHYSICIAN PER CLAIM FORM)

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. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	17. I.D. NUMBER OF REFERRING PHYSICIAN	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO
19. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE ITEMS 1,2,3 OR 4 TO ITEM 20E BY → 1. 2. 3. 4.		

20. 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 CPT HCPCS	MODIFIER	E. DIAGNOSIS CODE	F. $ CHARGES	G. DAYS OR UNITS	H. EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES

21. FEDERAL TAX I.D. NUMBER SSN ❑ EIN ❑	22. PATIENT'S ACCOUNT NO.	23. TOTAL CHARGE $	24. AMOUNT PAID $ / 25. BALANCE DUE $
26. 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	27. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (if other than home or office)	29. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # PIN # GRP #	

*PLACE OF SERVICE AND TYPE OF SERVICE (T.O.S.) CODES ON BACK REMARKS

HOW TO FILE A CLAIM

Items 1 through 12 of the top portion of the claim form must be filled out by you. The doctor, hospital or other supplier may complete the bottom portion of the form; or you may attach a copy of an itemized bill of the charges from the doctor or supplier. A sample of the part that you must complete is shown below.

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CITY / STATE	8. IS THERE ANOTHER HEALTH BENEFIT PLAN? ❑ YES ❑ NO IF YES, COMPLETE ITEM 9.	CITY / STATE
ZIP CODE / TELEPHONE (Include Area Code) ( )		ZIP CODE / TELEPHONE (Include Area Code) ( ) ❑ CHECK IF THIS IS A NEW ADDRESS
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO	
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (CURRENT OR PREVIOUS) ❑ YES ❑ NO	11. SUBSCRIBER'S POLICY GROUP NO. OR GROUP NAME
b. OTHER HEALTH INSURANCE COVERAGE NAME AND ADDRESS	b. AUTO ACCIDENT? ❑ YES ❑ NO	a. SUBSCRIBER'S DATE OF BIRTH MM | DD | YY
	c. OTHER ACCIDENT OR INJURY? ❑ YES ❑ NO	b. SUBSCRIBER'S SEX M ❑ F ❑ RETIRED? ❑ YES ❑ NO
c. INSURANCE PLAN NAME OR PROGRAM NAME	d. DATE OF ACCIDENT OR INJURY?	c. INSURANCE PLAN NAME OR PROGRAM NAME

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12. FOR OFFICE USE ONLY	**13. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICE DESCRIBED BELOW.**
	X PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE

INSTRUCTIONS

1. **Subscriber's Blue Cross and Blue Shield Contract Number -** Please fill in the insured's contract number exactly as shown on the insured's Blue Cross and Blue Shield identification card. You should double check this number to be sure it is correct.

2. **Patient's Name -** Please fill in the patient's name as it appears on the insured's Blue Cross and Blue Shield application.

3. **Patient's Birth Date -** Please enter month, day, year and check male or female. For example: May 21, 1958 would be 5/21/58.

4. **Subscriber's Name -** Please fill in the insured's name as it appears on the Blue Cross and Blue Shield identification card.

5. **Patient's Name -** Please fill in the patient's complete mailing address and correct telephone number.

6. **Patient Relationship to Insured -** Please check the block that indicates how the patient is related to the insured.

7. **Subscriber's Address -** Please enter the complete mailing address and telephone number of the Blue Cross and Blue Shield policyholder. If this information was already entered in item 5, then you may enter "same." If this is a new address, please check the box provided.

8. **Is there anther Health Benefit Plan? -** If the patient is covered by another group health policy, check the "yes" block and answer item 9.

9. **Other Insured's -** If the patient is covered by another group health policy through an employer or by Medicare, please fill in the policyholder's name.
   a. Other Insured's Policy or Group Number - Please fill in the policy number used by the other insurance coverage.
   b. Other Health Insurance Coverage Name and Address - Please enter the name and address used by the other insurance company.
   c. Insurance Plan Name - Please enter the plan or program name used by the other insurance company.

10. **Is Patient's Condition Related To -**
    a. Employment (Current or Previous) - Check yes or no.
    b. Auto Accident - Check yes or no.
    c. Other Accident or Injury - Check yes or no.
    d. Date of Accident or Injury - If a "Yes" block was checked in item 10, please indicate the date. Please enter month, day, year.

11. **Subscriber's Policy Group Number or Group Name -** Please enter the Group number as shown on the insured's Blue Cross and Blue Shield identification card. If this information is not available, please enter the name of the company that employs the insured.
    a. Subscriber's Date of Birth - Please enter month, day and year. For example: May 27, 1956 would be 5/27/56.
    b. Subscriber's Sex - Please indicate whether the insured is male or female and if that person is retired.
    c. Insurance Plan Name - Please enter the plan name or program name.

PLEASE NOTE

Blocks 1 through 11 of this form MUST be completed. If blocks 14-29 are not completed, the Doctor's statement of services rendered MUST be attached to this claim form. If the attending Doctor's statement is attached, the Doctor's signature is not required in block 26 of this claim form. Please submit only one patient per claim form and only one physician per claim form.

FOR PHYSICIAN/SUPPLIER USE ONLY

PLACE OF SERVICE CODES

1 - (IH)	- Inpatient Hospital	0 - (OL)	- Other Location
2 - (OH)	- Outpatient Hospital	A - (IL)	- Independent Laboratory
3 - (O)	- Doctor's Office	B - (ASC)	- Ambulatory Surgical Center
4 - (H)	- Patient's Home	C - (RTC)	- Residential Treatment Center
5 -	- Day Care Facility (PSY)	D - (STF)	- Specialized Treatment Center
6 -	- Night Care Facility (PSY)	E - (COR)	- Comprehensive Outpatient Rehabilitation Facility
7 - (NH)	- Nursing Home		
8 - (SNF)	- Skilled Nursing Facility	F - (KDC)	- Independent Kidney Disease Treatment Center
9 -	- Ambulance		

TYPE OF SERVICE CODES

1 - Medical Care	A - Used DME
2 - Surgery	F - Ambulatory Surgical Center
3 - Consultation	H - Hospice
4 - Diagnostic X-Ray	L - Renal Supplies in the Home
5 - Diagnostic Laboratory	M - Alternate Payment for Maintenance Dialysis
6 - Radiation Therapy	N - Kidney Donor
7 - Anesthesia	V - Pneumococcal Vaccine
8 - Assistance at Surgery	Y - Second Opinion on Elective Surgery
9 - Other Medical Services	Z - Third Opinion on Elective Surgery
0 - Blood or Packed Red Cells	