BlueCross BlueShield of Montana

# Claim Form
## to Pay Insured/Subscriber

P.O. Box 7982 • Helena, Montana 59604-8600

**Each item on this form needs to be completed.**
**Instructions for completion are listed on the reverse side.**

Please print or type.

**1**

**Insured/Subscriber Name** (Last, First, Middle Initial)

**Mailing Address**

**City and State** | **ZIP Code**

**Insured Employed?** ☐ Yes ☐ No ☐ Retired — Date of Retirement: Month Day Year _____/_____/_____

**2**

**Group Number** | **Insured/Subscriber Identification Number** (from ID card)

**Patient's Full Name** (Last, First, Middle)

**Patient's Sex** | **Patient's Date of Birth** Month Day Year _____/_____/_____

**Patient's Relationship to Insured**

☐ Self ☐ Spouse ☐ Child ☐ Other (explain) _____

**3**

**Type of treatment received:** Check only one type and attach itemized statements. Please use a separate claim form for each different type of treatment.

**Please note:** Preventive care includes immunizations, routine well baby care, routine physical examinations, vision and hearing exams.

| | **Provider information** | **Month Day Year** |
|---|---|---|
| ☐ Injury — Date of accident: | _____ | _____/_____/_____ |
| ☐ Illness — Date of first symptom: | _____ | _____/_____/_____ |
| ☐ Pregnancy — Date of conception: | _____ | _____/_____/_____ |
| ☐ Preventive — Date of service: | _____ | _____/_____/_____ |

**4**

**Describe: Diagnosis, symptoms of illness or injury or explain preventive or routine care received.**

_____

_____

_____

**5**

**If you experienced an injury or illness, is another party responsible for your treatment? (i.e., worker's compensation, motor vehicle accident, medical malpractice, slip-and-fall, etc.)** ☐ Yes ☐ No

**If you selected 'yes', please provide the name and address of your Attorney and/or Carrier information.**

_____

_____

**6**

**Is patient covered under any other health benefits plan (besides Medicaid, Medicare or CHAMPUS)?** ☐ Yes ☐ No

Insurance Co. _____

Address _____ Effective date of coverage Month Day Year _____/_____/_____

Employer _____ Sex of Insured ☐ Male ☐ Female

Insured name _____ Date of birth of insured _____/_____/_____

Policy # _____ Relationship to patient _____

**Attach the other insurance company's Explanation of Benefits, if available.**

**7**

**Medicare — Is the patient:**

| | | Month Day Year |
|---|---|---|
| a) Entitled to benefits under Medicare insurance (Part A)? | ☐ Yes ☐ No | Effective _____/_____/_____ |
| b) Entitled to benefits under Medicare insurance (Part B)? | ☐ Yes ☐ No | Effective _____/_____/_____ |
| c) Entitled to benefits under Medicare due to a disability? | ☐ Yes ☐ No | Effective _____/_____/_____ |

Patient's Medicare Identification Number. (From Medicare ID card) _____

**8**

I certify the above is complete and correct to the best of my knowledge and belief and that I am claiming benefits only for charges incurred by the patient named above. Authorization is hereby given to any Hospital, Physician, Dentist, Provider, Insurance Carrier or other entity to give Blue Cross and Blue Shield of Montana, upon request, any medical information which Blue Cross and Blue Shield of Montana in its judgment deems necessary to the adjudication of this claim. Any person who knowingly presents a false or fraudulent claim for the payment of a loss may be subject to prosecution and the imposition of fines, penalties or imprisonment.

| **Signature of Insured** | **Date** | **Daytime telephone number** |
|---|---|---|
| | | |

**9**

| Total amount for ALL covered services and supplies received. | **$** |
|---|---|

**Itemized Bill(s) for covered services and supplies must be attached.** ***(See Instructions on reverse side.)***

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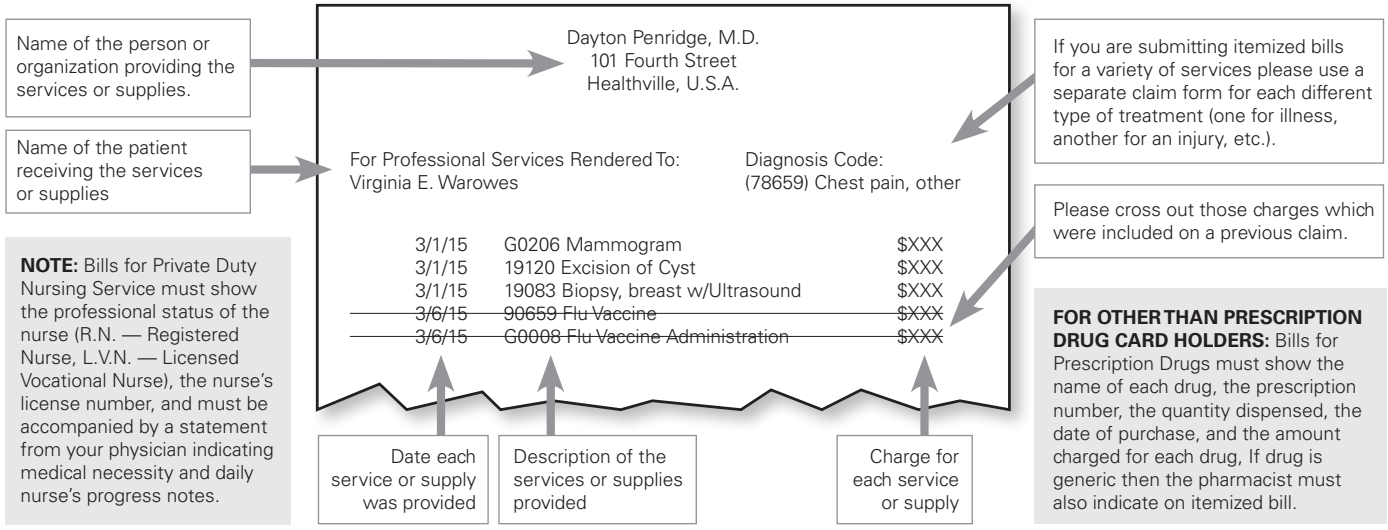
## INSTRUCTIONS

**Important: DO NOT file this form if your provider of service is submitting these charges to Blue Cross and Blue Shield of Montana.**

**Please complete every item on claim form.**

| | | |
|---|---|---|
| **1** | Insured/subscriber's name, address and employment status | Please show the insured/subscriber's name exactly as it appears on the Blue Cross and Blue Shield of Montana identification card and specify the current address including the ZIP code. Check appropriate box indicating the insured/subscriber's employment status. If retired, give date of retirement. |
| **2** | Patient information | Make sure the group number and identification number are exactly as shown on the insured's identification card. List patient's full name; no nicknames or initials. Check the appropriate blocks for the patient's sex and relationship to the insured. Ensure the patient's correct date of birth is shown. |
| **3** | Type of treatment received | Check only one treatment type (injury, illness, pregnancy or preventive care) and specify date of injury, date of first symptom, date of conception or date preventive care was received. You may attach multiple itemized statements if they are for one type of treatment (example: illness only, preventive care only). |
| **4** | Diagnosis or symptoms of illness or injury | Give diagnosis or a brief description of symptoms. If preventive care services were received, state the type of care (routine physical, hearing exam, vision exam, immunization or diagnosis, etc.). |
| **5** | If illness or injury is in any way work-related | Check appropriate box and enter name and address of employer. |
| **6** | If motor vehicle injury | Check appropriate box. |
| **7** | Other insurance | Please check appropriate box. If "yes," complete the required information. |
| **8** | Medicare information | Please check appropriate box concerning Medicare eligibility. If "yes," show effective date and give Medicare identification number.<br>Medicare enrollees should include a copy(s) of the Medicare Explanation of Benefits form(s) (EOB) with their itemized statements unless patient is actively employed and Medicare requires the patient's group coverage to pay before Medicare pays. |
| **9** | Insured's signature, date and daytime telephone number | Please sign and date this form and attach your physician's itemized letterhead statement(s). The itemized statement(s) should contain all the information shown in the following example: |
| **10** | **Example of Itemized Bill — Please remember to attach the original bill(s) to the claim form and make a copy for your records. Itemized bills cannot be returned.** | |




**NOTE:** Bills for Private Duty Nursing Service must show the professional status of the nurse (R.N. — Registered Nurse, L.V.N. — Licensed Vocational Nurse), the nurse's license number, and must be accompanied by a statement from your physician indicating medical necessity and daily nurse's progress notes.

**FOR OTHER THAN PRESCRIPTION DRUG CARD HOLDERS:** Bills for Prescription Drugs must show the name of each drug, the prescription number, the quantity dispensed, the date of purchase, and the amount charged for each drug, If drug is generic then the pharmacist must also indicate on itemized bill.

This completed form, together with the itemized bills, should be submitted to:

Blue Cross and Blue Shield of Montana
P.O. Box 7982
Helena, Montana 59604-8600