Horizon

Horizon Blue Cross Blue Shield of New Jersey
P.O. Box 1609
Newark, New Jersey 07101-1609
(PLEASE TYPE OR PRINT)

Health Insurance Claim Form

I. POLICYHOLDER

1. POLICYHOLDER'S NAME (Last, First, Middle Initial)

2. POLICYHOLDER'S IDENTIFICATION NUMBER
PREFIX (if any) | NUMBER PORTION | SUFFIX (if any)

3. POLICYHOLDER'S ADDRESS (No., Street) CITY STATE ZIP CODE

4. TELEPHONE NUMBER (Include Area Code)
( )

5. POLICYHOLDER'S SOCIAL SECURITY NUMBER
___ ___ ___-___ ___-___ ___ ___ ___

6. POLICYHOLDER'S BIRTH DATE
Month Day Year
_____/_____/_____

6a. POLICYHOLDER'S SEX
☐ Male ☐ Female

7. EMPLOYER'S NAME

8. IF THIS IS A GROUP POLICY, INDICATE THE GROUP NUMBER

II. PATIENT

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

10. IS PATIENT'S CONDITION RELATED TO:
a. EMPLOYMENT? (Current or Previous) ☐ YES ☐ NO
b. AUTO ACCIDENT ☐ YES ☐ NO STATE IN WHICH AUTO ACCIDENT OCCURRED: _____
c. OTHER ACCIDENT ☐ YES ☐ NO
d. DATE OF ACCIDENT Month Day Year _____/_____/_____
DATE OF YOUR FIRST SYMPTOM OF ILLNESS Or, if Pregnant, Date of your Last Menstrual Period Month Day Year _____/_____/_____

11. PATIENT'S BIRTH DATE
Month Day Year
_____/_____/_____

11a. PATIENT'S SEX
☐ Male ☐ Female

12. PATIENT STATUS
☐ Married ☐ Single ☐ Other

13. PATIENT'S RELATIONSHIP TO POLICYHOLDER
☐ Policy Holder ☐ Spouse ☐ Child ☐ Other

14. IS PATIENT
☐ Employed ☐ Full-Time Student ☐ Part-Time Student

III. COORDINATION OF BENEFITS

15. DOES THE PATIENT HAVE OTHER HEALTH INSURANCE? ☐ YES ☐ NO
IF YES, COMPLETE ITEMS 15a-h AND SEE INSTRUCTIONS ON BACK

15a. IF MEDICARE, CHECK HERE AND ATTACH EOMB ☐
(See instructions and example of EOMB on back)

15b. OTHER POLICYHOLDER'S NAME (Last, First, Middle Initial)

15c. OTHER POLICYHOLDER'S BIRTH DATE
Month Day Year
_____/_____/_____

15d. OTHER POLICYHOLDER'S SEX
☐ Male ☐ Female

15e. OTHER POLICYHOLDER'S ADDRESS (No., Street) CITY STATE ZIP CODE

15f. OTHER INSURANCE PLAN'S NAME

15g. OTHER POLICYHOLDER'S IDENTIFICATION NUMBER AND GROUP NUMBER

15h. OTHER INSURANCE PLAN'S ADDRESS (No., Street) CITY STATE ZIP CODE

IV. AUTHORIZATION

16. I certify that the information provided on this claim form is correct and complete, and that I am claiming benefits only for charges actually incurred by the patient named. I authorize any hospital, physician or other provider who participated in the care and treatment of the patient to release to Horizon Blue Cross Blue Shield of New Jersey, Inc., all medical or other information requested for the processing of this claim form. I hereby agree to reimburse Horizon Blue Cross Blue Shield of New Jersey, Inc., in full should this claim be incorrectly paid.

AUTHORIZED SIGNATURE DATE (AREA CODE) HOME PHONE (AREA CODE) WORK PHONE

WHEN YOU ARE SUBMITTING EXPENSES FOR MORE THAN ONE FAMILY MEMBER, PLEASE USE A SEPARATE CLAIM FORM FOR EACH PERSON.

ITEMIZED BILLS FOR COVERED SERVICES OR SUPPLIES MUST BE ATTACHED TO THIS FORM AND INCLUDE THE FOLLOWING:

Check that each itemized bill is legible and contains ALL of the following information:

- ☑ NAME & ADDRESS of person or institution rendering the service or supplying the item
- ☑ PROVIDER'S Federal Tax Identification Number
- ☑ PATIENT'S FULL NAME
- ☑ TYPE of service rendered or item supplied
- ☑ DATE each service rendered or item supplied
- ☑ AMOUNT charged for each service rendered or item supplied
- ☑ DIAGNOSIS of ailment

BILLS MISSING ANY OF THIS INFORMATION WILL DELAY PROCESSING AND MAY BE RETURNED TO YOU

Cash register receipts, cancelled checks, money order receipts, personal itemizations, and bills only noting a "balance due" are not acceptable.

17. AUTHORIZATION FOR ASSIGNMENT OF BENEFITS
Horizon Blue Cross Blue Shield of New Jersey, Inc., at its discretion, may accept an Assignment of Benefits. I the undersigned, authorize and request Horizon Blue Cross Blue Shield of New Jersey Inc., to make payment for benefits which may be due herein to:

NAME OF PROVIDER PROVIDER'S TAX OR SOCIAL SECURITY NUMBER SIGNATURE OF POLICYHOLDER DATE

SEE BACK OF THIS FORM FOR IMPORTANT INFORMATION

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).**

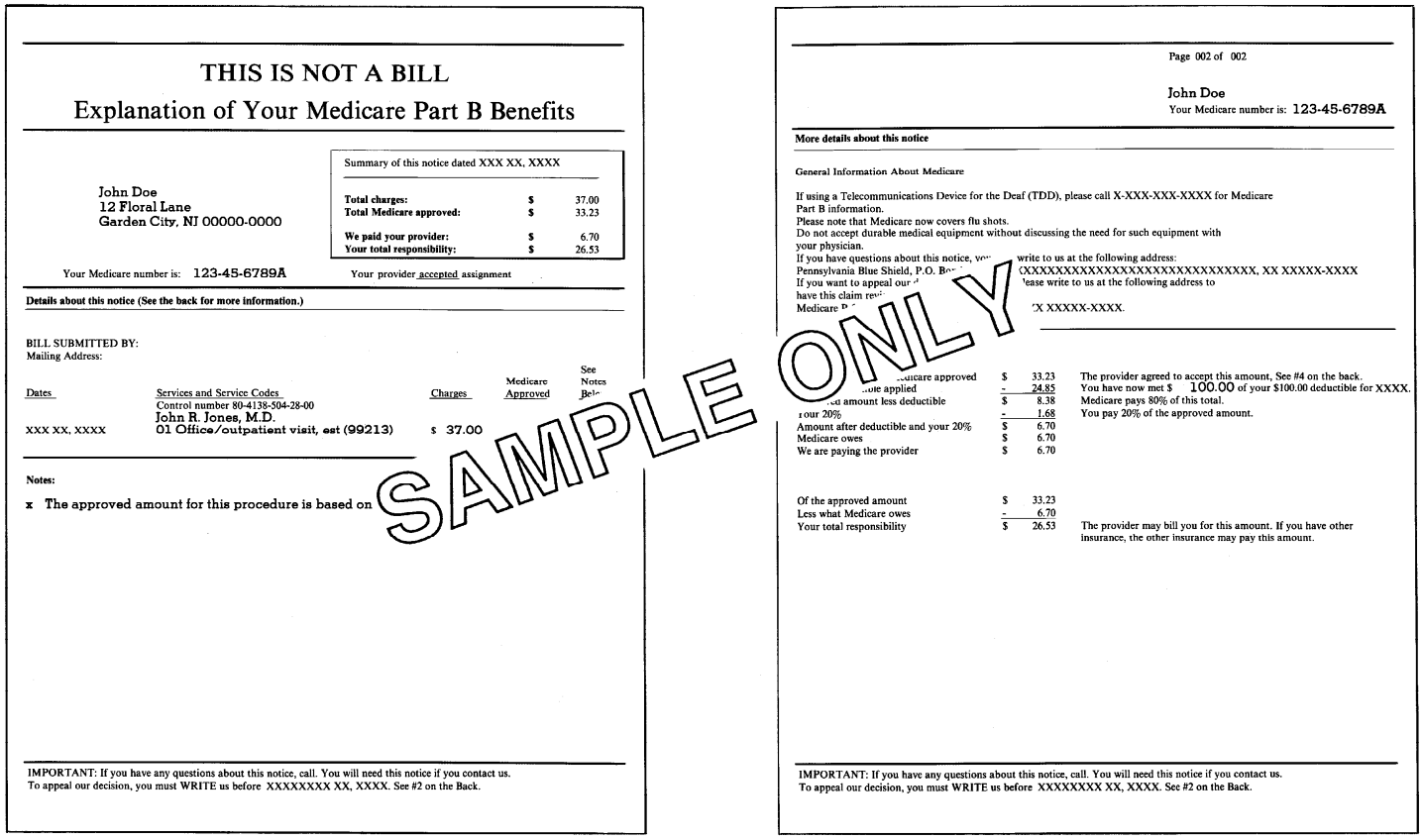
MEDICARE?

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 Bel-
	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

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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, you write to us at the following address:
Pennsylvania Blue Shield, P.O. Box XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX, XX XXXXX-XXXX
If you want to appeal our d lease write to us at the following address to have this claim rev
Medicare P X XXXXX-XXXX.

...dicare approved	$	33.23	The provider agreed to accept this amount, See #4 on the back.
...ble applied	-	24.85	You have now met $ 100.00 of your $100.00 deductible for XXXX.
...ed amount less deductible	$	8.38	Medicare pays 80% of this total.
Your 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 1609
Newark, New Jersey 07101-1609

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.