



Horizon Blue Cross Blue Shield of New Jersey P.O. Box 820 Newark, New Jersey 07101-0820

(PLEASE TYPE OR PRINT)

Horizon POS Health Insurance Claim Form

	1. POLICYHOLDER'S NAME (Last, First, Middle Initial)		2. POLICYHOLDER'S PREFIX (if any)	S IDENTIFICATION NUMBER NUMBER PORTION	SUFFIX (if any)
POLICYHOLDER	3. POLICYHOLDER'S ADDRESS (No., Street)	CITY		STATE	ZIP CODE
I. POLICY	4. TELEPHONE NUMBER (Include Area Code) () 7. EMPLOYER'S NAME	5. POLICYHOLDER'S SOCIAL SECURITY NU	UMBER	6. POLICYHOLDER'S BIRTH DATE Month Day Year	6a. POLICYHOLDER'S SEX Male Female
	1. EMPLOTER 3 NAME			8. IF THIS IS A GROUP POLICY, IND	ICATE THE GROUP NUMBER
L	9. PATIENT'S NAME (Last, First, Middle Initial)		a. EMPLOYME (Current or Pre	I LYES I INO	
II. PATIENT	11. PATIENT'S BIRTH DATE Month Day Year 11a. PATIENT'S 13. PATIENT'S RELATIONSHIP TO POLICYHOLDER Policy Spouse Child Other	SEX 12. PATIENT Married Female Single Other 14. IS PATIENT Employed Full-Time Student Student	b. AUTO ACCI c. OTHER ACC d. DATE OF A Month	CIDENT YES NO	
LS	15. DOES THE PATIENT HAVE OTHER HEALTH INSURANCE? IF YES, COMPLETE ITEMS 15a-h AND SEE INSTRUCTIONS ON BACK 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)				
F BENEFITS				HER POLICYHOLDER'S BIRTH DATE fonth Day Year	15d. OTHER POLICYHOLDER'S SEX Male Female
ATION O	15e. OTHER POLICYHOLDER'S ADDRESS (No., Street)	CITY		STATE	ZIP CODE
COORDINATION OF	15f. OTHER INSURANCE PLAN'S NAME		15g. OTHER POLICYHOLDER'S IDENTIFICATION NUMBER AND GROUP NUMBER		
≡	15h. OTHER INSURANCE PLAN'S ADDRESS (No., Street	et) CITY		STATE	ZIP CODE
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 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 r 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					w Jersey, Inc., all medical or other
	AUTHORIZED SIGNATURE	DATE	(AREA CODE)	HOME PHONE (AREA C	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

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

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

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).

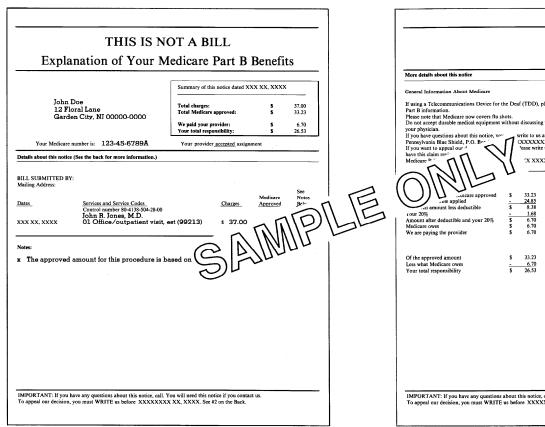
MEDICARE?

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 you 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 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.



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.

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.

Prescription Drugs? Bills must show the prescription number, name and quantity of drug, and the name and address of the pharmacy.

Please mail completed claim form to:

Horizon POS
Horizon Blue Cross Blue Shield of New Jersey
P.O. Box 820
Newark, New Jersey 07101-0820

FRAUD WARNING -

ANY PERSON WHO KNOWINGLY FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE OR MISLEADING INFORMATION IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES