[redacted]

Empire BlueCross BlueShield

POB 1407
CHURCH STREET STATION,
NEW YORK, NY 10008-1407

APPROVED OMB-0938-0008

NOTE: Important filing instructions on next page.

CARRIER

PICA

HEALTH INSURANCE CLAIM FORM MEMBER SUBMITTED

PICA

PATIENT AND INSURED INFORMATION

1. MEDICARE ☐ (Medicare #)	MEDICAID ☐ (Medicaid #)	CHAMPUS ☐ (Sponsor's SSN)	CHAMPVA ☐ (VA File #)	GROUP HEALTH PLAN ☐ (SSN or ID)	FECA BLK LUNG ☐ (SSN)	OTHER ☐ (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

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

3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No. and Street)

6. PATIENT RELATIONSHIP TO INSURED
Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No. and Street)

CITY | STATE

8. PATIENT STATUS
Single ☐ Married ☐ Other ☐
Employed ☐ Full-Time Student ☐ Part-Time Student ☐

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code)

ZIP CODE | TELEPHONE (Include Area Code)

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) ☐ YES ☐ NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? ☐ YES ☐ NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER NAME OR BENEFIT PLAN? ☐ YES ☐ NO If YES, return to and complete item 9a–d.

READ BACK OF FORM BEFORE COMPLETING THIS SECTION.

12. I AUTHORIZE THE RELEASE OF INFORMATION AS DESCRIBED ON THE REVERSE SIDE OF THIS CLAIM FORM.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PHYSICIAN SUPPLIER INFORMATION

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. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE)
1. ____ . __ 3. ____ . __
2. ____ . __ 4. ____ . __

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. 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 (EXPLAIN UNUSUAL CIRCUMSTANCES) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT FAMILY PLAN	I EMG	J COB	K RESERVED FOR LOCAL USE
1												
2												
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? ☐ YES ☐ NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER, INCLUDING DEGREES OR CREDENTIALS
I CERTIFY THAT THE CARE, SERVICES AND SUPPLIES ENTERED ON THIS FORM HAVE BEEN RENDERED TO THE PATIENT, AND THAT I AM ENTITLED TO REIMBURSEMENT OF THE CHARGES INDICATED.

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIANS, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE AND PHONE NUMBER

PIN# | GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90)
FORM OWCP-1500

FILING INSTRUCTIONS

MEMBERS: You are required to complete this claim form if you receive services from a nonparticipating physician (any physician that is "out-of-network").

1. Complete the patient and insured information sections **(Boxes 1–12)**.
   - Please make sure the three-letter alpha prefix, along with the insured's member identification number, appears in **Box 1a. Do not complete Box 13**.
2. Attach the original itemized bill from the physician to the claim form and mail it to the address listed on the front of the form.

   OR

   Have the physician complete the physician supplier information sections **(Boxes 14–33).** And mail it to the address listed on the front of the form.

NOTE: If you receive services from a participating physician (an "in-network" physician), you are not required to complete any claim forms. All participating network physicians submit claims directly to their local Blue Cross and/or Blue Shield plan.

If you have any questions about completing this claim form, please call the Customer Service telephone number listed on the front of the form or the number on the back of your member identification card.

PROVIDERS: If you have rendered services to a member, please complete the physician supplier information sections **(Boxes 14–33)**. Then mail it to the address listed on the front of the form.

PATIENT'S SIGNATURE

The patient must sign the claim form, authorizing the release of information to Empire or its designee as described below. If the patient is a minor, the signature must be that of the patient's parent or legal guardian.

I authorize any healthcare provider, payor of health claims or government agency to furnish to Empire or its designee all records pertaining to medical history, services rendered, or payments made regarding me or my dependents for review and evaluation of any claim or services.

I authorize Empire or its designee to disclose such information to another payor or self-insurer. If my coverage is under a group contract held by an employer, association, trust fund, union or similar entity, this authorization also permits disclosure to them for purposes of utilization review or financial audit.

This authorization shall become effective immediately, and shall remain in effect until the latest of six years after the termination of coverage, or the last determination or payment by Empire on a claim or service under the coverage. This authorization shall be binding upon me, my dependents, my heirs, executors or administrators.

FRAUD STATEMENT

Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto, may be guilty of a criminal act punishable under law and may be subject to civil penalties.

Member Medical Claim Form

See reverse side before filing your claim.

Empire BlueCross BlueShield

An Anthem Company

Section 1: Member information

Member last name	First name	M.I.
Member identification no. – This is required to process your claim.	Group no.	
Street address	City	State / ZIP code

Section 2: Patient information

Patient last name	First name	M.I.
Sex ☐ Male ☐ Female / Date of birth (MMDDYYYY)	Relationship to subscriber ☐ Self ☐ Spouse ☐ Son ☐ Daughter	

Section 3: Diagnosis

What is the illness or injury?	If accident, give date: →	Date of accident (MMDDYYYY)

Section 4: Work-related

Was this a work-related injury or illness? ☐ Yes ☐ No If yes, complete the following:

Employer name			
Street address	City	State	ZIP code

Section 5: Other group health insurance

Is this patient covered by another group health plan? ☐ Yes ☐ No If yes, complete the following:

Policyholder name	Policyholder date of birth	Other insurance company name	Policy ID no.	Group no.

Section 6: Medicare

Is this patient covered by Medicare? ☐ Yes ☐ No If yes, give patient's Medicare health insurance claim no.: _____

☐ Part A – Effective date: (MMDDYYYY) ☐ Part B – Effective date: (MMDDYYYY)

☐ Part D – Effective date: Part D carrier/company name: _____

Section 7: Authorization and signature(s) – Required.

The patient must sign the claim form, authorizing the release of information to Empire or its designee as described below. If the patient is a minor, the signature must be that of the patient's parent or legal guardian. I authorize any health care provider, payor of health claims, or government agency to furnish to Empire or its designee all records pertaining to medical history, services rendered, and payments made regarding me or my dependents for review and evaluation of any claim or services. I authorize Empire or its designee to disclose such information to another payor or self-insurer. If my coverage is under a group contract held by an employer, association, trust fund, union, or similar entity, this authorization also permits disclosure to them for purposes of utilization review or financial audit. This authorization shall become effective immediately, and shall remain in effect until the latest of six years after the termination of coverage, or the last determination or payment by Empire on a claim or service under the coverage. This authorization shall be binding upon me, my dependents, my heirs, executors or administrators.

I certify that the above statements are complete and correct to the best of my knowledge and that I am claiming benefits only for charges incurred by the above named patient.

Important Fraud Warning Statement: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed $5,000 and the stated value of the claim for each such violation.

Patient signature or authorized representative X	Date (MMDDYYYY)
Member signature X	Date (MMDDYYYY)

How to request benefits

Use this form to file a claim when your doctor doesn't file the claim for you. You should send this completed claim form as soon as possible after you get care. Check your certificate of coverage for specific deadlines to submit your claim.

Step 1: Complete **all** areas of the *Claim Form* before returning the claim to us. If benefits are to be claimed for more than one family member, a separate claim form must be submitted for each member.

Step 2: Include the itemized bill you got from your doctor. It must include:

- Name, address, and tax ID number of provider (doctor, hospital, laboratory, ambulance service, etc.)
- Name of patient
- Service provided
- Date of service
- Place of service
- Amount charged for each service
- Diagnosis code
- Procedure code

Cancelled checks, cash register receipts and non-itemized "balance due" statements cannot be processed.

Step 3: Sign and date the claim form.

Step 4: Recheck **all** information and submit this form along with a copy of your itemized bill to:

Empire BlueCross BlueShield
P.O. Box 1407
Church Street Station
New York, New York 10008-1407

Have questions or need help? Give us a call at the Member Services number on your ID card.
You may also use the secure online customer service form at empireblue.com.