HEALTH BENEFITS CLAIM FORM

CareFirst

PLEASE COMPLETE A SEPARATE CLAIM FORM FOR EACH FAMILY MEMBER.
(SEE REVERSE SIDE FOR FILING INFORMATION)

PLEASE COMPLETE EACH NUMBERED ITEM - FAILURE TO DO SO MAY RESULT IN DELAYS IN PROCESSING YOUR CLAIM

PLEASE TYPE OR PRINT

*THIS FORM CAN ALSO BE USED FOR FILING CLAIMS FOR CAREFIRST BLUECHOICE OPT-OUT *PLUS*.

1. IDENTIFICATION NUMBER	2.GROUP NUMBER OR ENROLLMENT CODE	3.PATIENT'S NAME (FIRST, MIDDLE INITIAL, LAST)

4. PATIENT'S DATE OF BIRTH	5. PATIENT'S SEX	6. PATIENT'S RELATIONSHIP TO SUBSCRIBER:
MO DAY YEAR ___/___/___	FEMALE ❑ MALE ❑	*EE* *SP* *CH* SELF ❑ SPOUSE ❑ CHILD ❑ OTHER ❑ EXPLAIN:

7. SUBSCRIBER'S NAME (FIRST, MIDDLE INITIAL, LAST)

8.DAYTIME TELEPHONE NUMBER (INCLUDE AREA CODE) ( ) —

9. SUBSCRIBER'S ADDRESS (STREET, CITY, STATE, ZIP CODE) CHECK IF NEW ADDRESS ❑

10. IS PATIENT COVERED UNDER OTHER HEALTH INSURANCE? NO ❑ YES ❑ IF YES, NAME OF OTHER INSURANCE COMPANY

NAME OF POLICY HOLDER

POLICY OR IDENTIFICATION NUMBER

IS PATIENT COVERED UNDER MEDICARE? NO ❑ YES

IF THE SUBSCRIBER IS MARRIED, IS THE SPOUSE EMPLOYED? NO ❑ YES ❑

❑ IF YES, PART A ❑ PART B ❑ MEDICARE HIC NUMBER

IF YES, GIVE THE NAME OF THE SPOUSE'S EMPLOYER

IS PATIENT ACTIVELY EMPLOYED? NO ❑ YES ❑ IF YES, NAME OF EMPLOYER

11. WAS PATIENT'S CONDITION DUE TO: AUTO ACCIDENT? NO ❑ YES ❑ ANY OTHER ACCIDENTAL INJURY? NO ❑ YES ❑ WORK RELATED ACCIDENT OR CONDITION? NO ❑ YES

❑ MEDICAL EMERGENCY? NO ❑ YES ❑

IF AN ACCIDENT, GIVE THE DATE OF THE ACCIDENT MO DAY YEAR ___/___/___

WAS ANOTHER PARTY AT FAULT? NO ❑ YES ❑

IF MEDICAL EMERGENCY GIVE DATE SYMPTOMS BEGAN MO DAY YEAR ___/___/___

IF YES, ATTACH A STATEMENT WITH DETAILS (SEE ACCIDENTAL INJURY ON THE REVERSE SIDE)

12.WAS PATIENT HOSPITALIZED? NO ❑ YES ❑

ADMISSION DATE MO DAY YEAR ___/___/___

IF YES, COMPLETE THE FOLLOWING:

DISCHARGE MO DAY YEAR ___/___/___

NAME OF HOSPITAL

NAME & ADDRESS OF ADMITTING PHYSICIAN

13.ARE BILLS FOR A CONSULTATION ATTACHED? NO ❑ YES ❑ IF YES, GIVE NAME OF PHYSICIAN WHO REQUESTED THE CONSULTATION

WAS THE CONSULTATION REQUESTED TO OBTAIN A SECOND SURGICAL OPINION? NO ❑ YES ❑

WAS SURGERY RECOMMENDED? NO ❑ YES ❑

14.ARE BILLS FOR MATERNITY ATTACHED? NO ❑ YES ❑ IF YES, WHAT IS THE DATE OF THE LAST MENSTRUAL PERIOD? MO DAY YEAR ___/___/___

15.STATE THE DIAGNOSIS, SYMPTOMS, ILLNESS OR INJURY FOR THE EXPENSES CLAIMED

HAS PATIENT HAD THESE SYMPTOMS/CONDITION BEFORE? NO ❑ YES ❑ IF YES, WHEN MO DAY YEAR ___/___/___

GIVE DATE SYMPTOM(S) FIRST STARTED MO DAY YEAR ___/___/___

GIVE DATE PHYSICIAN FIRST SEEN MO DAY YEAR ___/___/___

16.LIST BELOW ONLY THOSE CHARGES BEING CLAIMED AND ATTACH ORIGINAL ITEMIZED BILLS FROM THE PROVIDERS FOR THESE SERVICES

NAME(S) OF PROVIDER(S)	*DESCRIPTION(S) OF SERVICE(S)*	*DIAGNOSIS (IF MORE THAN ONE)*	*FROM DATE* MO DAY YEAR	*TO DATE* MO DAY YEAR	*CHARGE*
A.			___/___/___	___/___/___	$.
B.			___/___/___	___/___/___	$.
C.			___/___/___	___/___/___	$.
D.			___/___/___	___/___/___	$.

17. TOTAL $.

18. THIS CLAIM FORM MUST BE SIGNED. IF NOT, IT WILL BE RETURNED.

I request benefits for these expenses and certify that the above information is correct and that the foregoing expenses were incurred for the above named patient. I authorize any physician, nurse, hospital or other providers or suppliers in possession of information concerning the patient to furnish such information to CareFirst BlueCross BlueShield upon request.

Subscriber Signature

Date MO DAY YEAR ___/___/___

Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

AUTHORIZATION FOR ASSIGNMENT OF BENEFITS (SEE REVERSE)

I, the undersigned, authorize CareFirst BlueCross BlueShield to make payment for benefits due herein to

Name of Provider

Provider's Tax or Social Security Number

Name of Provider

Provider's Tax or Social Security Number

Subscriber Signature

Date MO DAY YEAR ___/___/___

CareFirst BlueCross BlueShield is the business name of Group Hospitalization and Medical Services, Inc. and is an independent licensee of the Blue Cross and Blue Shield Association.
® Registered trademark of the Blue Cross and Blue Shield Association. ®′ Registered trademark of CareFirst of Maryland, Inc.