BlueCross BlueShield
Federal Employee Program

Health Benefits Claim Form

Please review the instructions on the reverse side of this form before completing.

1. PATIENT INFORMATION

1A. ENROLLMENT INFORMATION
Enrollment Code ☐☐☐ Identification Number ☐☐☐☐☐☐☐☐☐☐

1B. PATIENT'S NAME (First, Middle Initial and Last)

1C. PATIENT'S DATE OF BIRTH (mm/dd/yyyy)

1D. PATIENT'S SEX ◯ Male ◯ Female

1E. NAME OF ENROLLEE OR POLICY HOLDER (First, Middle Initial and Last)

1F. DATE OF BIRTH (mm/dd/yyyy)

1G. PATIENT'S RELATIONSHIP TO ENROLLEE ◯ Self ◯ Spouse ◯ Child

1H. ENROLLEE'S CURRENT ADDRESS (Street, City, State and ZIP Code)

CHECK IF NEW ADDRESS ☐

1I. EMAIL ADDRESS

PLEASE COMPLETE INFORMATION BELOW ONLY IF IT HAS CHANGED SINCE YOU LAST GAVE IT TO US. IF NO CHANGES, GO TO #5.

2. OTHER HEALTH INSURANCE Is the patient covered by additional health insurance through an employer, a group such as a professional organization, or any other group health insurance, including other Blue Cross and/or Blue Shield Coverage?
◯ Yes ◯ No If answered yes, complete 2A through 2E; if answered no, go to Section 3.

2A. NAME AND ADDRESS OF INSURING COMPANY (Street, City, State and ZIP Code)

2B. EFFECTIVE DATE (mm/dd/yyyy)

TERMINATION DATE (mm/dd/yyyy)

2C. NAME OF POLICY HOLDER AND HIS/HER EMPLOYER (First, Middle Initial and Last)

2D. DATE OF BIRTH (mm/dd/yyyy)

2E. IDENTIFICATION NUMBER (Include all letters and numbers)

3. MEDICARE PLEASE COMPLETE THIS SECTION ON MEDICARE REGARDLESS OF THE PATIENT'S AGE If you are covered by a Medicare HMO/Prepaid Plan, please leave Sections 3A and 3B Blank

3A. MEDICARE PART A (Hospital Insurance) ◯ Yes ◯ No
If yes, effective date (mm/dd/yyyy)

3B. MEDICARE PART B (Medical Insurance) ◯ Yes ◯ No
If yes, effective date (mm/dd/yyyy)

3C. MEDICARE HMO/ PREPAID PLAN ◯ Yes ◯ No
If yes, effective date (mm/dd/yyyy)

3D. If the patient is eligible for Medicare due to End-Stage Renal Disease, please indicate the beginning date of renal treatment or transplant. (mm/dd/yyyy)

4. **EMPLOYMENT**

4A. Is the patient presently employed? If the patient is retired from the Federal Government, but still employed, please complete 4B ◯ Yes ◯ No

4B. NAME AND ADDRESS OF COMPANY OR GOVERNMENT AGENCY (Street, City, State, and ZIP Code)

5. DIAGNOSIS Describe illness, injury or symptoms requiring treatment. If illness, injury or symptoms are related to an accident, please complete 5A, 5B and 5C.

5A. DATE OF ACCIDENT (mm/dd/yyyy)

5B. TIME OF ACCIDENT ◯ AM ◯ PM

5C. LOCATION OF ACCIDENT ◯ At Home ◯ At Work ◯ Motor vehicle accident ◯ Other
If a Motor vehicle accident, what state

Was the accident caused by someone else? ◯ Yes ◯ No
Please Explain

6. CHARGES **Please list below those charges that you are claiming for benefits. Use a separate line for each type of service or provider. PLEASE ATTACH ITEMIZED BILLS**

NAME OF PROVIDER MAKING CHARGE (Doctor, Hospital, etc. Two or more bills from the same provider may be entered on one line if they are for the same type of service.)	**DESCRIPTION OF CHARGE** (Office Visits, Therapy from Mental Conditions, etc.)	**DATE OF SERVICE OR PURCHASE: FROM** (If there is only one date, indicate it as the "FROM DATE".)	**DATE OF SERVICE OR PURCHASE: TO**	**CHARGE**

I certify the above is complete and correct and that I am claiming benefits only for charges incurred as listed above. Authorization is hereby given to any provider of service, which participated in any way the medical care or services provided, to release to the Blue Cross and/or Blue Shield Plan any medical information which they deem necessary to adjudicate this claim.

7. SIGNATURE OF PATIENT OR AUTHORIZED REPRESENTATIVE

(Signature) (Date) (Best telephone number to call including area code)

Failure to sign this claim form may delay processing.

The Blue Cross and Blue Shield Service Benefit Plan

Clear Form

INSTRUCTIONS

Please complete a separate claim form for each patient, and remember to file all claims by December 31 of the calendar year after the one in which the covered care or service was provided. Since most of the information requested on this form is self-explanatory, we did not include specific instructions for each item. However, please complete each item. If the information requested does not apply to the patient, indicate N/A (NOT APPLICABLE).

Special care should be taken when completing the following items:
1A and 2E: These spaces are for the Blue Cross and Blue Shield Service Benefit Plan Enrollment Code and Identification Number (Item 1A) and other Health Insurance Identification Number (Item 2E). When completing these items, please ensure that these numbers and letters are exactly as they appear on your identification card(s).

3A, B and C: Medicare covers persons age 65 and over and persons who qualify because of disabling conditions such as End-Stage Renal Disease. **THEREFORE, PLEASE COMPLETE ITEMS 3A AND B REGARDLESS OF THE PATIENT'S AGE.** Item C should be completed if applicable.

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

- Name and address of the provider of the service or supply
- Full name of the patient
- Date and type of service or supply
- Charge for each service or supply
- Diagnosis
- Provider Identification Number

Personal itemizations, cash register receipts and cancelled checks are not acceptable. Since itemized bills cannot be returned, please be sure to make copies for your records. In addition, bills for home nursing care must show the professional status, such as R.N. (Registered Nurse). Bills for all drugs and medicines dispensed by a physician, the outpatient department of a hospital or any other non-retail-pharmacy provider must show the name of each drug or medicine.

RETAIL PHARMACY PROGRAM
Claims for prescription drugs and supplies filled by a Preferred retail pharmacy in the U.S. or Puerto Rico will be filed for the member. Preferred pharmacies will not file claims for drugs requiring prior approval. Claims for drugs not filed by a retail pharmacy must be submitted to the Retail Pharmacy Program by the member on the Retail Prescription Drug Claim Form. This form can be downloaded from the following link: www.fepblue.org.

You can also call 1-800-624-5060 for more information, claim forms and customer service assistance. The claim form provides detailed instructions for submission of the form and should be mailed to: Service Benefit Plan Retail Pharmacy Program, P.O. Box 52057, Phoenix, AZ 85072-2057.

SPECIAL SERVICES
Certain services such as physical, speech and occupational therapy, durable medical equipment, home nursing care and dental care resulting from an accidental injury may require additional information along with this claim form. Call your local Blue Cross and/or Blue Shield Plan before submitting your claim for such services; they will send you additional forms, if needed.

FOR PATIENTS COVERED BY MEDICARE
When the patient is covered by Medicare Part A (Hospital Insurance) and/or Medicare Part B (Medical Insurance) and incurs expenses which are covered by Medicare, if Medicare is primary (it pays first), your claim must be submitted to Medicare first (See Note Below). After the Medicare payment has been made, a claim for the expenses not paid by Medicare, to include a copy of your Itemized bill, can be submitted to your local Blue Cross and/or Blue Shield Plan, along with the appropriate forms from Medicare. For retail pharmacy prescription drug expenses, see the instructions above.

1. For Medicare Part A inpatient services, attach the "Explanation of Benefits" form from Medicare.
2. For Medicare Part B services, attach the "Explanation of Medicare Benefits" and/or the "Your Record of Part B Medicare Benefits Used" form furnished by the Medicare Carrier or Intermediary. Also, a copy of your itemized bill should be sent along with the Medicare Information.

NOTE: If the following conditions are met, the Blue Cross and Blue Shield Service Benefit Plan is primary (it pays first).

- If you are 65 or over and employed by the Federal Government and have Medicare Part A (or Parts A and B);
- If you or your spouse are employed by the Federal Government and your covered spouse is 65 or over and has Medicare Part A (or Parts A and B);
- If the patient (you or a covered family member) is under 65, eligible for Medicare benefits only because of End-Stage Renal Disease (ESRD) and is within the first 18 months of eligibility to receive Medicare Part A benefits; or
- If the patient (you or a covered family member) is under age 65 and eligible for Medicare solely on the basis of disability, and you are employed by the Federal Government

FOR PATIENTS COVERED BY OTHER HEALTH INSURANCE
When submitting charges for services or supplies that have been partially paid by other group health insurance, attach a copy of the Notice of Payment or Explanation of Payment from the other health care insurer.

THIS COMPLETED FORM, TOGETHER WITH ITEMIZED BILLS AND SUPPORTING MATERIAL, SHOULD BE SUBMITTED TO YOUR LOCAL BLUE CROSS AND/OR BLUE SHIELD PLAN. THE MAILING ADDRESS FOR YOUR LOCAL PLAN CAN BE LOCATED ON FEPBLUE.ORG BY USING THE FOLLOWING LINK: WWW.FEPBLUE.ORG/CONTACT