



An Independent Licensee of the Blue Cross and Blue Shield Association

MEMBER HEALTH EXPENSE REPORT

MAIL TO:

Blue Cross and Blue Shield of Georgia
P.O. Box 9907
Columbus, GA 31908-6007

PLEASE SEE INSTRUCTIONS FOR FILING ON THE REVERSE SIDE.

| | | | |
|----------|--|---|---|
| 1 | MEMBER NUMBER | GROUP NUMBER | NUMBER OF ITEMS ATTACHED |
| 2 | PATIENT INFORMATION - Person who received services: | | |
| | NAME (last, first, MI) | SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE | RELATIONSHIP TO SUBSCRIBER <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER |
| | | | DATE OF BIRTH Mo. Day Yr. |
| 3 | PRIMARY MEMBER INFORMATION: | | |
| | NAME | ADDRESS | |
| | | <input type="checkbox"/> IMPORTANT Check here if this is a new address | |
| 4 | OTHER COVERAGE INFORMATION: | | |
| | IS THIS PATIENT COVERED BY ANY OTHER GROUP HEALTH PLAN OR MEDICARE? <input type="checkbox"/> YES <input type="checkbox"/> NO | WAS CONDITION RELATED TO AN AUTOMOBILE ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| | | WAS CONDITION RELATED TO EMPLOYMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| | IF "YES" to either of the above questions, please complete the following: | | |
| | Policyholder's Name | Date of Birth | Policy Number |
| | Insurance Company's Name | Please indicate type of coverage <input type="checkbox"/> Health <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Drug | |
| | Insurance Company's Address | City | State Zip Code |
| | Employer's Name | Group Number | Medicare Number Medicare Effective Date Medicare <input type="checkbox"/> Part A <input type="checkbox"/> Part B |
| 5 | MEDICAL INFORMATION: | | |
| | IS THIS AN ILLNESS <input type="checkbox"/> OR INJURY <input type="checkbox"/> | IF INJURY, DATE OF INJURY IS REQUIRED | MO DAY YR |
| | Describe the illness or injury which required treatment | | |
| | How did the injury occur? | | |
| 6 | PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE - I authorize the release of any medical information necessary to process this claim and also certify that the above information is correct. | | READ THIS Any intentional false statement in this application or willful misrepresentation relative thereto is a violation of the law. |
| | SIGNED | DATE | |
| 7 | EACH BILL MUST HAVE THE NAME OF THE PHYSICIAN PROVIDING SERVICES AND HIS/HER SIGNATURE. | | |

If you have questions or need any assistance, please call **1-800-441-CARE (2273)**
Monday - Friday 7am to 7pm.
www.bcbsga.com

Please see instructions
on the reverse side.

INSTRUCTIONS FOR COMPLETION OF THE MEMBER HEALTH EXPENSE REPORT

Blue Cross and Blue Shield of Georgia (BCBSGA) / Blue Cross Blue Shield Healthcare Plan of Georgia (BCBSHP) value your membership. The following tips are offered to ensure accurate and timely processing of your claim.

The instructions for completion of this Report are listed below, in sequence of the numeric order on the first page:

- 1
 - Record the member and group number exactly as it appears on the member identification card.
 - Indicate the total number of items attached to the Report in the block provided.

- 2
 - The patient is the person who received the health care services or supplies. The patient's name should be included on every statement filed, along with the date of service.

Different claim forms must be filed for each patient/member.
 - Indicate the patient's sex and relationship to the primary member and the patient's date of birth in the fields provided.

- 3
 - The primary member is the employee insured by BCBSGA / BCBSHP. The primary member's name, current address, and zip code should be completed in this section. If the member has a new address, the change address box should be checked.

- 4
 - If the patient has no other coverage, simply check 'no'.
 - If the patient is covered by another group health insurance program or MEDICARE, check "YES" and furnish the following: policyholder's name, policy number, the insurance company's name and address, the policyholder's employer, and the insurance group number.
 - If the patient is covered by Medicare, please enter the Medicare number and check the appropriate box for Part A and/or Part B, along with the effective date.
 - If the patient is covered by another health insurance company or Medicare, the corresponding Explanation of Benefits must be attached. Failure to provide this information will delay the claim and require a request of additional information.

- 5
 - Describe the illness or injury for which treatment was necessary. In the case of multiple illnesses, please indicate the diagnosis on each itemization attached. If the treatment was due to an injury, provide the date and details of how the accident occurred.

- 6
 - The patient (or authorized person) should sign and date the Report.

- 7
 - Each bill should contain the rendering physician's name and his/her signature.

OTHER TIPS FOR FILING A CLAIM

- Ensure all statements are itemized and include a charge and a description of each service rendered. If the statement reads 'labs' or 'x-rays', the description of the procedure should be included, and can be obtained by contacting the provider.
- Statements that read 'Balance Due' cannot be processed and will be returned.
- Ensure the provider's name is listed on each statement.
- Any associated hospital charges should be filed separately.
- If claims are filed from a provider that is participating with BCBSGA / BCBSHP, the payment will be sent directly to the provider.
- If you are required to pay up-front or receive balance billing from a participating provider, please contact customer service immediately.
- It is always prudent to make copies of the items submitted.
- Mail the claim to BCBSGA / BCBSHP at the address listed on the front of the Report.

If you need any assistance or have questions, log on to www.bcbsga.com or call customer service at 1-800-441-CARE (2273) from 7AM to 7PM Monday through Friday .