



# Health Advantage

An Independent Licensee of the Blue Cross and Blue Shield Association

P.O. Box 8069  
Little Rock, Arkansas 72203-8069

## CLAIM FORM

A SEPARATE CLAIM FORM MUST BE SUBMITTED FOR EACH PATIENT  
WHEN SENDING BILLS TO HEALTH ADVANTAGE

Please refer to the instructions on back of this form when filing your claims.

HEALTH ADVANTAGE IDENTIFICATION NUMBER \_\_\_\_\_ GROUP NUMBER \_\_\_\_\_  
(as indicated on your identification card including the three-digit prefix)

PATIENT'S INFORMATION	Patient's Last Name		Complete First Name		Initial	Date of Birth		
	Mo. ____ Day ____ Yr. ____		Sex		Patient's Relationship to Policyholder			
	<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other (Specify)					
	Description of illness or injury requiring treatment.						Date Illness Began: Mo. ____ Day ____ Yr. ____	
	Was this an accident? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, date of accident Mo. ____ Day ____ Yr. ____		Was this an automobile accident?		Was the illness/accident related to employment? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Is patient a full time student? <input type="checkbox"/> Yes <input type="checkbox"/> No			If yes, what school?					

OTHER INSURANCE	<b>THIS PART MUST BE COMPLETED IN FULL BEFORE WE CAN DETERMINE RESPONSIBILITIES FOR YOUR CLAIM.</b>						
	Do you have Medicare?						
	Part A: <input type="checkbox"/> No <input type="checkbox"/> Yes; Effective Date _____				If yes, please file the claim with Medicare first. Then submit a copy of your Explanation of Medicare Benefits with this form.		
	Part B: <input type="checkbox"/> No <input type="checkbox"/> Yes; Effective Date _____						
	Is the patient covered by other medical insurance? <input type="checkbox"/> No <input type="checkbox"/> Yes				If yes, and the policy is with a group (such as through an employer), please complete the following section.		
	Name of insured policyholder:			Name and address of insured's employer:			
Name and Address of other insurance company:					Policy Number (other insurance co.)		
Type of Coverage:		Has the other insurance company paid?					
<input type="checkbox"/> Single <input type="checkbox"/> Family		<input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, please submit a copy of their payment information with this form.			

POLICYHOLDER'S INFORMATION	Policyholder's Last Name			First Name	Initial	Policyholder's Employer	
	Policyholder's Address						
	Street		City		State		Zip
	I certify the above is complete and correct and that I am claiming benefits for charges incurred by the above named patient.						
Policyholder's Signature _____						Date _____	

IF YOU HAVE ANY QUESTIONS, PLEASE CONTACT CUSTOMER SERVICE AT 800-843-1329.

## GENERAL INFORMATION

You should submit your bills in a timely manner. To speed the processing of your claim, all bills must be itemized and attached to the claim form. ALL items on the claim form must be completed to insure proper payment.

**NOTE: CANCELLED CHECKS, PAYMENT RECEIPTS, OR BALANCE FORWARD BILLS ARE NOT ACCEPTABLE**

## HOW TO FILE A CLAIM

### 1. PREPARATION OF BILLS

#### A. Separate bills into the following groups:

- |   |   |                    |                    |
|---|---|--------------------|--------------------|
| 1. Physician's Bills                                  | 3. Nurse's Bills                              | 5. Ambulance Bills | 7. Durable Medical |
| 2. Drug Bills or Blue Cross<br>Pharmacist's Statement | 4. Physical Therapy &<br>Speech Therapy Bills | 6. Hospital Bills  | Equipment Bills    |
|   |   |                    | 8. Other Bills     |

#### B. Check the bills for the following information:

1. Physician's Bills - (Must be submitted on physician's office bill or a Blue Shield claim form.)
  - a. Full name of patient
  - b. Date(s) of service
  - c. Full description of the type of procedures, medical services or supplies furnished for each date.
  - d. Amount charged for each service
  - e. Diagnosis
2. Drug Bills or Health Advantage Pharmacist's Statement - (Must be submitted on official pharmacy invoice or stationery)
  - a. Full name of patient
  - b. Date(s) of purchase
  - c. Prescription number
  - d. Amount charged for each prescription
  - e. Name of drug
3. Nurse's Bills - (Must have registration or license number of R.N. or L.P.N.)
  - a. Full name of patient
  - b. Professional status (i.e., R.N., or L.P.N., etc.) of each service
  - c. Beginning and ending dates of the nursing service
  - d. Time & number of hours worked
  - e. Charge for the nursing service
  - f. Nurse's name
4. Physical Therapy and Speech Therapy Bills - (Must be on therapist's stationery)
  - a. Full name of patient
  - b. Date(s) of service
  - c. Charge for each service
  - d. Name of licensed therapist
5. Ambulance Bills (Bills must be on ambulance firm's letterhead)
  - a. Full name of patient
  - b. Mileage of trip
  - c. Charges per mile
  - d. Points of departure and mileage
  - e. Description of other services (i.e., oxygen, equipment, etc.)
  - f. Charge for each service
  - g. Total amount charged
6. Hospital Bills
  - a. Itemized statement from hospital, which must include diagnosis
7. Durable Medical Equipment Bills - (Bill must include an invoice from the supplying firm) NOTE: On purchase of equipment, you must receive prior approval from Arkansas Blue Cross and Blue Shield to be eligible for payment
  - a. Full name of patient
  - b. Date(s) of services
  - c. Description of items
  - d. Charge for each item
  - e. Must have supporting statement from physician.
8. Other Bills - (Must include an invoice from the person or organization who provided the services)
  - a. Name of person or organization who provided the services
  - b. Full name of patient
  - c. Date the service was provided
  - d. Description of services
  - e. Charge for each service

#### NOTE:

DO NOT USE THIS FORM TO FILE CHARGES WHICH ARE BEING FILED FOR YOU BY THE HOSPITAL AND/OR PHYSICIAN. PLEASE CHECK WITH THE HOSPITAL AND/OR PHYSICIAN (OR OTHER PROVIDERS OF CARE) BEFORE FILING THE CLAIM YOURSELF.

### 2. PREPARATION OF CLAIM FORM

#### A. Patient information (things to remember)

1. Enter FULL name of patient; patient's date of birth (month, day and year), and be sure to check the relationship to Policy/Certificate Holder block.

#### B. Policy/Certificate Holder Information (things to remember)

1. You must enter FULL first and last name, middle initial.
2. You must enter the correct and complete identification and group numbers for claim to be processed.
3. You must enter the correct and complete address for mailing of payment.

IF YOU HAVE ANY QUESTIONS, PLEASE CONTACT CUSTOMER SERVICE AT 800-843-1329.

## NON-DISCRIMINATION AND LANGUAGE ASSISTANCE NOTICE

**NOTICE:** Our Company complies with applicable federal and state civil rights laws and does not discriminate, exclude, or treat people differently on the basis of race, color, national origin, age, disability, or sex.

We provide free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters, written information in various formats (large print, audio, accessible electronic formats, other formats), and language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. **If you need these services, contact our Civil Rights Coordinator.**

If you believe that we have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

### **Civil Rights Coordinator**

601 Gaines Street, Little Rock, AR 72201  
Phone: 1-844-662-2276; TDD: 1-844-662-2275

You can file a grievance in person, by mail, or by email. If you need help filing a grievance our Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

### **U.S. Department of Health and Human Services**

200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201  
Phone: 1-800-368-1019; TDD: 1-800-537-7697

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

**ATTENTION: Language assistance services, free of charge, are available to you. Call 1-844-662-2276.**

**ATENCIÓN:** si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-844-662-2276.

**注意:** 如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-844-662-2276。

**CHÚ Ý:** Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-844-662-2276.

**주의:** 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-844-662-2276 번으로 전화해 주십시오.

**PAUNAWA:** Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-844-662-2276.

**ВНИМАНИЕ:** Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-844-662-2276.

**ملاحظة:** إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. إتصل بالرقم 1-844-662-2276.

**ATANSYON:** Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-844-662-2276.

**ATTENTION :** Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-844-662-2276.

**UWAGA:** Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-844-662-2276.

**ATENÇÃO:** Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-844-662-2276.

**ATTENZIONE:** In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-844-662-2276.

**注意事項 :** 日本語を話される場合、無料の言語支援をご利用いただけます。1-844-662-2276 まで、お電話にてご連絡ください。

**ACHTUNG:** Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-844-662-2276.

**توجه:** اگر بہ زبان فارسی صحبت می‌کنید، خدمات و کمک‌های زبانی رایگان برای شما موجود است. برای کسب اطلاعات بیشتر، با شماره 1-844-662-2276 تماس بگیرید.

**सुचना:** જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-844-662-2276.

**ध्यान दें:** यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-844-662-2276 पर कॉल करें।

**LUS CEEV:** Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-844-662-2276.

**انتباه:** اگر آپ اردو بولتے ہیں تو، آپ کے لئے زبان کی مدد کی خدمات بلا معاوضہ دستیاب ہیں۔ 1-844-662-2276 پر کال کریں۔

**ໂປດຊາບ:** ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 1-844-662-2276.

**LALE:** Ñe kwōj kōnono Kajin Majōl, kwomaroñ bōk jermal in jipañ ilo kajin ñe aṃ ejje!ok wōñāān. Kaalok 1-844-662-2276.