CUSTOMER CLAIM FORM

Please read instructions on reverse side.

Mail completed forms and receipts to:
Blue Cross Blue Shield of Delaware
P.O. Box 8831
Wilmington, DE 19899-8831

BENEFITS WILL BE ADMINISTERED IN ACCORDANCE WITH THE TERMS OF YOUR BENEFIT PLAN.

1. CUSTOMER'S NAME

Last

First M.I.

CUSTOMER'S ADDRESS ☐ Check box for change of address

City State Zip Code

Area Code Telephone Number

2. If you, your spouse, or dependent children insured under this Benefit Plan, are also covered under any other health insurance plan, please indicate:

Name of Insured Person

Policy Number

Name of Health Insurance Company

Address of Health Insurance Company

3. PATIENT'S NAME

Last

First M.I.

PATIENT'S SEX

☐ Male ☐ Female

PATIENT'S RELATIONSHIP TO INSURED

☐ Self ☐ Spouse ☐ Child

PATIENT'S DATE OF BIRTH / /

ACCOUNT NUMBER

IDENTIFICATION NUMBER—Include any letters

4. Was the treatment required as a result of an accident or injury?
☐ Yes ☐ No How and where did the incident happen?

Date of incident (month, day, year) ______/______/______

5. Medical condition (diagnosis) or symptoms requiring treatment:

6. Check category(ies) for which you are submitting receipts and list total charges:

☐ **Physician Home & Office Visits.** For charges from physicians, please submit on the physician's letterhead or billing form. This must include: $ ________________
- Patient's name
- Date of service
- Diagnosis or symptoms
- Charge for each service
- Type of service

☐ **Prescription Drugs.** For charges from a pharmacy, statements must include: $ ________________
- Patient's name
- Prescribing physician
- Name of drug
- Dispensing date
- Charge for prescription

☐ **Appliances and Durable Medical Equipment.** For charges from a company providing these items, the statement must include: $ ________________
- Patient's name
- Name of equipment/appliance
- Prescription from physician describing need for equipment/appliance
- Date of purchase or rental
- Charge for equipment/appliance

☐ **Psychiatric Services (out-of-hospital).** For charges from a psychiatrist or licensed psychologist please submit a statement on the provider's letterhead or billing form. This must include $ ________________
- Patient's name
- Date of service
- Diagnosis or symptoms
- Charge for each service
- Treating physician
- Length of session (e.g.,1/2 hr.,1 hr.)
- Type of service

☐ **Private Duty Professional Nursing (In-hospital only).** For charges from a professional nurse, please submit a statement and a physician's prescription certifying the necessity of the services ordered. The nurse's statement must include: $ ________________
- Patient's name
- Name of hospital
- Nurse's name, license number and R.N. or L.P.N. designation
- Diagnosis
- Dates of admission & discharge
- Date(s) of service
- Hours & shift for each service
- Nurse's signature
- Charge for each service

☐ **Hospital Services.** Attach itemized statements and/or bills. $ ________________

☐ **Other Services specifically included in your benefit plan.** Please refer to your benefit literature before using this section. Statements must be on the provider's letterhead or billing form. Attach itemized statements and/or bills. $ ________________

TOTAL CHARGES, ALL CATEGORIES $ ________________

7. I certify that all of the information provided by me, including statements/bills listed above, is correct and complete to the best of my knowledge and that I am claiming benefits for charges incurred by the patient named above.

Customer's Signature:______________________________ **Date:** ________/________/________

INSTRUCTIONS

IMPORTANT !

PLEASE READ THE FOLLOWING INSTRUCTIONS BEFORE COMPLETING THE REVERSE SIDE.

Do not wait until the end of the year to file your claims as this causes unnecessary delays in processing. Claims must be submitted no later than 18 to 24 months (check benefit plan for specifications) from the time the service was rendered to be considered for payment.

Your original itemized statements/bills cannot be returned. **You should keep photocopies for your own records.**

A. When filing a claim, please:

1. Complete form using black or blue ink.
2. Answer all questions on the reverse side of this form. Missing or incomplete information may result in delayed processing or possibly the return of your claim(s) for additional information.
3. Submit a separate claim form for each family member for whom you are making a claim.
4. Attach itemized statements and bills that have been completed by professional medical sources.
   - Pharmacy bags are acceptable as itemized statements for prescription drug charges as long as they contain all the required information.
   - The following are not acceptable as proof for incurred charges:
     a. Canceled checks
     b. Cash register receipts
     c. Visa/MasterCard receipts
     d. Statements prepared by the person(s) submitting this claim form.
5. Translate itemized statements and bills into English for services received outside the United States.
6. Mail completed forms and itemized bills to: Blue Cross Blue Shield of Delaware
   P.O. Box 8831
   Wilmington, DE 19899-8831

B. Please use this space to give us any additional details which may be helpful to us in processing this request.

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C. Did you remember to:
- Attach your receipts
- Indicate the diagnosis
- Date this claim form
- Sign this claim form

Thank you for choosing Blue Cross Blue Shield of Delaware. We look forward to serving you.

Blue Cross Blue Shield of Delaware is an independent licensee of the Blue Cross and Blue Shield Association.