1 **Employee's** Name _____

Identification Number _____
(Please include the letters if included on your ID Card)

FOR OFFICE USE ONLY

HEALTH BENEFITS CLAIM FORM

South Carolina

BlueCross BlueShield of South Carolina is an independent licensee of the Blue Cross and Blue Shield Association

Piedmont Service Center
Post Office Box 6000
Greenville, SC 29606-6000

2 **Patient's** Name _____
First Middle Initial Last

3 The **Patient** is: ☐ Female ☐ Male

And Is The: ☐ Employee ☐ Employee's Spouse ☐ Employee's Child

4 **Patient's** Date of Birth Month __ __ Day __ __ Year __ __

5 **Employee's** Mailing Address ☐ Check If New Address _____
Street City State ZIP Code

6 Was any treatment required as a result of accidental injury? ☐ Yes ☐ No Date of accident _____

7 If an accident, was another person at fault? ☐ Yes ☐ No If yes, please explain. _____

Was any injury or illness work related? ☐ Yes ☐ No

8 Is the patient covered by Medicare Health Insurance, Part A? ☐ Yes ☐ No
Or by Supplemental Medical Insurance, Part B? ☐ Yes ☐ No
If yes, please attach your "Explanation of Medicare Benefits." It is necessary to process your claim.
Complete the following Medicare Health Insurance Benefit Number # _____

9 Is the patient covered under any other health benefit plan? ☐ Yes ☐ No
If yes, please attach your "Explanation of Benefits" from the other Insurance Company. Also, please complete this entire section as it is necessary to process this claim.

A. Policyholder's Name _____

Relationship of Policyholder to Patient _____

B. Name of other Policyholder's Employer _____

Address of other Policyholder's Employer _____
City State ZIP Code

C. Name of other Insurance Company _____

Address of other Insurance Company _____

CERTIFICATION OF MEMBER

10 I certify that the above information is correct and that the foregoing expenses were incurred for the above named patient. I request eligible benefits for these expenses. I authorize any physician, nurse, hospital or other provider or supplier in possession of records or information concerning the patient to furnish such information to Blue Cross and Blue Shield of South Carolina upon request. (Be sure to complete items 1-9 on this form and attach itemized statements for all expenses. **Absence of this information may cause a delay in processing this claim.**)

Date _____ Employee's Signature _____

EXAMPLES OF
PHYSICIANS, MEDICAL EQUIPMENT, PHARMACIST AND NURSING BILLS

The following are properly filed itemized bills

MEDICAL AND SURGICAL BILLS

SHOULD INCLUDE THE FOLLOWING:

- (A) Physician name and address.
- (B) Full name of patient should appear on every bill, not just name of person paying bill.
- (C) The date of surgery or medical treatment.
- (D) The type of surgery performed or type of medical treatment.
- (E) Separate cost for each treatment.

Harry Smith, M.D. (A)
Columbia, S.C.

Patient John Jones (B)

(C) 9/18/96	Surgery, Appendectomy (D)	(E) 250.00
9/17 - 23/96	Hospital Calls (D)	No Charge
(C) 10/23/96	(D) Office Call	No Charge
12/1/96	Office Call–Virus (D)	15.00
	Injection (D)	5.00

MEDICAL EQUIPMENT

SHOULD INCLUDE THE FOLLOWING:

ACE-BRACE Co.
Columbia, S.C.

(A)
Patient Nancy Smith (C) **Date** 9/17/96

Address 2905 Start Rd. **Phone** 788-1234

Dr. Jones (B)

Quantity	Rx	Price
1	Wheelchair - Economy (D)	299.00
	TAX	11.96
		310.96

- (A) Full name of patient.
- (B) Name of Doctor ordering Medical Equipment.
- (C) Date Medical Equipment purchased.
- (D) Description of equipment purchased.

Note:- Letter of medical necessity is required before major medical will process.

DRUGGIST BILLS

SHOULD INCLUDE THE FOLLOWING:

- (A) Full name of patient. (Separate bill should be submitted for each member of family for whom major medical expense benefits are being claimed.)
- (B) Date of purchase.
- (C) Prescription number, quantity, name and strength of drug.
- (D) Separate charge for each prescription.
- (E) Pharmacist's signature.

PRICE PHARMACY
200 Market Street
Columbia, S.C.
Patient:
(A) Mary G. Jones

Date	Prescription Number Description	Charge
(B) 8/31/96	(C) 575-516 60 Aldoril25mg Dr. G.S. Smith	(D) 11.60
	588-152 60 HCTZ50mg Dr. G.S. Smith	7.25
10/1/96	592-321 30 Aldoril25mg Dr. G.S. Smith	6.20
12/9/96	599-472 60 Aldoril25mg Dr. G.S. Smith	11.60
(E)		36.65

NURSING BILLS

SHOULD INCLUDE THE FOLLOWING:

(A)
NURSE Diane Smith RN

LICENSE OR REGISTRY NO. (A) 12345

(B)
FOR Mr. Ed Johnson

PLACE OF TREATMENT (C) Home Care

(B)
ADDRESS 123 2nd St., Columbia, S.C.

DATES WORKED	SHIFTS/HOURS	CHARGE
12/8/96 (D)	(E) 7-3 p.m./8 hrs.	
12/9/96	7-3 p.m./8 hrs.	40.00
12/10/96	11-7 a.m./8 hrs	40.00
TOTAL HOURS	24 hrs.	

- (A) Nursing bills must clearly indicate whether the nurse is a Registered Nurse (RN) or Licensed Practical Nurse (LPN). Also the license or Registry Number.
- (B) Name and address of patient.
- (C) Were nursing services provided in Hospital, Home or Elsewhere?
- (D) Dates worked.
- (E) Shift and/or hours worked.