# County Health Pool
# Health Fair Claim Form

## Subscriber Submitted Claim

*One patient and one provider per claim form see reverse side for claim filing instructions.*

| | | | |
|---|---|---|---|
| 1. Number | | 2. Group No. | |
| 3. Patient Name *(Last, First, Initial) (Please Print)* | | 4. Patient Birth Date | 5. Patient Sex Male Female |
| 6. Patient Relationship to Subscriber Self Spouse Child Other | 7. Subscriber Name *(Last, First, Initial) (Please Print)* | | |
| 8. Subscriber Address Street (Street, City, State, Zip Code) | | | |

**COORDINATION OF BENEFITS INFORMATION - ANSWER "YES" OR "NO" TO ALL QUESTIONS**

| | | | |
|---|---|---|---|
| 9. Is Patient Covered By Any Other Group Health Benefit Plan? *(IF NO GO TO QUESTION 11)* Yes No | | | |
| 10a. Name of Policyholder | 10b. Name and Address of Insurance Company | | 10c. Policy Number |
| 11a. Is Patient Eligible for Part A and/or Medicare? *(IF NO GO TO QUESTION 14)* PART A Yes No PART B Yes No | | 11b. Medicare Number | |
| 12. Illness or Symptoms – For Reimbursement **Diagnosis V70.0** | | | |
| 13. Name of Provider or Hospital Facility of Service **Health Fair** | | 14. If We Have Questions, Who May We Contact? Name: Phone No: | |
| 15. If Place of Service was Outpatient Hospital, Provide Name of Hospital Facility | | | |

**PLEASE COMPLETE THE FOLLOWING AS A SUMMARY OF THE ITEMIZED BILLS YOU HAVE ATTACHED TO THIS CLAIM FORM**

| 16. Date of Service | 17. Place of Service* | 18. Charge for Service | 19. Briefly Describe the Service(s) You Received |
|---|---|---|---|
| | 22 | | **Health Fair Labs - 80050** |
| | 22 | | **PSA - 84153** |
| | | | |
| | | | |
| | | | *Check box next to services you have received |
| 20. Total Charges for which You are Requesting Consideration of Payment $ | | | **Place of Service H = home NH = Nursing Home P = Pharmacy L = Lab* |

21. I CERTIFY TO THE ACCURACY AND COMPLETENESS OF ALL INFORMATION REPORTED BY ME ON THIS FORM AND AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM. Signature Date

**FULL SIGNATURE AND DATE REQUIRED ON EACH FORM INCOMPLETE FORMS MAY DELAY PROCESSING.**
**PLEASE ENSURE ALL FIELDS ARE ANSWERED.**

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## SUBSCRIBER CLAIM FILING INFORMATION *(HOW TO FILE)*

Be sure to ask your provider of care if he/she bills a statement to Anthem Blue Cross and Blue Shield. Please submit statements only if the provider does not bill us directly. To receive benefits for RX, or for services by a provider who does not bill us directly, complete the claim form, attach itemized bills, and mail the white copy to Anthem Blue Cross and Blue Shield, P.O. Box 5747, Denver, Colorado 80217-5747. Keep a duplicate copy of your itemized bills as they will not be returned to you. **This claim may be returned to you if all required information is not present.**

## CLAIM FILING INSTRUCTIONS *(CORRESPONDS TO NUMBERED ITEMS ON CLAIM FORM)*

**A separate claim form for each family member and each provider of care must be submitted.**

**ITEM NO.** 1–9 Please complete all blocks. All fields required.
10 Coordination of additional insurance.
11 Medicare eligibility.
14 Name and telephone number; whoever can help provide additional information if required.
15 If laboratory or radiology services are being billed by a professional provider, and the place of service was inpatient or outpatient hospital, indicate the name of the hospital.
16 Use a separate line for each date of service and receipt.
17 Write the appropriate code to indicate the place of service by using the legend below this section.
18 Indicate the total charge for each service.
19 Briefly indicate the type of service, i.e. lab, X-ray, surgery, therapy, cast, stitches, etc.
20 This amount represents the total of all charges to be considered for benefit.
21 Your signature attests to the accuracy and completeness of all information on the claim and the attachments and authorizes the release of your medical records by the provider to our office if necessary.

## REQUIRED INFORMATION

**Itemized Bills:** Summarizing the services may help us better understand the attachments if they are not clear. The **attached** itemized bills must include the provider name, patient's name, date of service, detailed description of service, and amount charged for that service. These must be valid documents from the provider. **Psychotherapy:** Length and type of session (group or individual). Name and professional status of the individual conducting the session. **Prescription Drugs:** Patient's name, pharmacy name and address, purchase date, **drug name**, prescription number and charge. The bill or receipt must be issued by the pharmacy.

## HELPFUL HINTS

“ If you have questions or need assistance, contact Anthem Blue Cross and Blue Shield Customer Service. “ To reduce the possibility of small billings getting lost or separated, it would be helpful if you attach these to an 8 1/2x11 piece of paper. “ We encourage you to file claims within 90 days of the service date. Please refer to your Benefit Certificate for specific timely filing limitations. “ File only if the provider has not. **Important:** If the services for this claim were provided by a participating physician or hospital, the benefit payment will go to the provider. However, if you paid this participating provider in full, attach a copy or your cancelled check or receipt and we will direct the benefit payment to you. Indicate "PAID IN FULL" under item 24. **A complete description of your benefits, as well as limitations and exclusions applicable thereto, is available in the Benefit Certificate. Final interpretation of any and all provisions of the program is governed by the Benefit Certificate.**