Pennsylvania BlueShield

An Independent Licensee of the Blue Cross and Blue Shield Association

PO BOX 890173
CAMP HILL, PA 17089-0173

CLAIM FORM

PATIENT & INSURED (SUBSCRIBER) INFORMATION

READ INSTRUCTIONS BEFORE COMPLETING OR SIGNING THIS FORM

1. PATIENT'S NAME *(First name, middle initial, last name)*
2. PATIENT'S DATE OF BIRTH
3. INSURED'S NAME *(First name, middle initial, last name)*
4. PATIENT'S ADDRESS *(Street, city, state, ZIP code)*

   TELEPHONE NUMBER
5. PATIENT'S SEX — MALE / FEMALE
6. INSURED'S I.D. *(include any letters)*
7. PATIENT'S RELATIONSHIP TO INSURED — SELF / SPOUSE / CHILD / OTHER
8. INSURED'S GROUP NO. *(Or Group Name)*
9. OTHER HEALTH INSURANCE COVERAGE-Enter Name of Policyholder and Plan Name and Address and Policy or Medical Assistance Number
10. WAS CONDITION RELATED TO
    A. PATIENT'S EMPLOYMENT — YES / NO
    B. AN ACCIDENT — AUTO / OTHER
11. INSURED'S ADDRESS *(Street, city, state, ZIP code)*

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. The signer hereby authorizes any insurer, employer, organization or health care service provider to release to the plan all information relating to past, present and future health care examinations or treatments received by each person covered by this claim/application.

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF ◀ ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)
15. DATE FIRST CONSULTED YOU FOR THIS CONDITION
16. HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS? YES / NO

16A. IF AN EMERGENCY CHECK HERE

17. DATE PATIENT ABLE TO RETURN TO WORK
18. DATES OF TOTAL DISABILITY — FROM / THROUGH

DATES OF PARTIAL DISABILITY — FROM / THROUGH

19. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE *(e.g., public health agency)*
20. FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES — ADMITTED / DISCHARGED
21. NAME & ADDRESS OF FACILITY WHERE SERVICES RENDERED *(If other than home or office)*
22. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE? YES / NO CHARGES

23A. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY RELATE DIAGNOSIS TO PROCEDURE IN COLUMN E BY REFERENCE NUMBER 1, 2, 3, ETC. OR DX CODE

1
2
3
4

24. A DATE OF SERVICE FROM	TO	B PLACE OF SERVICE	C T O S	D FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN — PROCEDURE CODE (IDENTIFY:)	(EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)	E DIAGNOSIS CODE	F CHARGES	G DAYS OR UNITS	H PERFORMING PROVIDER

25. SIGNATURE OF PHYSICIAN OR SUPPLIER *(I certify that the statements on the reverse apply to this bill and are made a part hereof.)*

    SIGNED DATE
26. HAS FEE BEEN PAID? YES / NO
27. TOTAL CHARGE
28. AMOUNT PAID
29. BALANCE DUE
30. YOUR SOCIAL SECURITY NO.
31. PHYSICIAN'S OR ACCOUNT'S NAME, ADDRESS, ZIP CODE & PROVIDER NO.
32. YOUR PATIENT'S ACCOUNT NO.
33. YOUR EMPLOYER I.D. NO.
34. YOUR TELEPHONE NO.

1500A-1 10/02 *PLACE OF SERVICE CODES ON THE BACK REMARKS:

SIGNATURE OF PHYSICIAN

I certify that the services reported on this form were medically necessary for the patient and were performed by personally or in my presence, or were performed under my supervision by my employee. If the services were performed under my supervision by someone other than my employee, I have described the circumstances in item 24D. I understand that certain types of supervised services may not be covered. I will provide documentation as necessary to establish the validity of the claim

PLACE OF SERVICE CODES:

Code		Description
1 - (IH)	-	Inpatient Hospital
2 - (OH)	-	Outpatient Hospital
3 - (O)	-	Doctor's Office
4 - (H)	-	Patient's Home
5 -	-	Day Care Facility (PSY)
6 -	-	Night Care Facility (PSY)
7 - (NH)	-	Nursing Home
8 - (SNF)	-	Skilled Nursing Facility
9 -	-	Ambulance
0 - (OL)	-	Other Locations
A - (IL)	-	Independent Locations
B -	-	Other Medical Surgical Facility
C - (RTC)	-	Residential Treatment Center
D - (STF)	-	Specialized Treatment Facility