HIGHMARK Delaware

CUSTOMER CLAIM FORM

Please read instructions on reverse side.

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

BENEFITS WILL BE ADMINISTERED IN ACCORDANCE WITH THE TERMS OF YOUR BENEFIT PLAN. *(Please complete form using black or blue ink.)*

1. CUSTOMER'S NAME

Last

First M.I.

CUSTOMER'S ADDRESS ❑ Check box for change of address

Street

City State Zip Code

Area Code Telephone Number

2. If you, your spouse, or dependent children insured under this benefits 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 and 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 code and symptoms
- Charge for each service
- Service code (CPT or HCPCS) and description 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

❑ **Certain Over-The-Counter Drugs:** Please refer to instructions on reverse for further details on items to include when submitting this form. $_____

❑ **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
- Service code (CPT or HCPCS)

❑ **Mental Health Services (out-of-hospital):** For charges from 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
- Length of session (e.g., 1/2 hr., 1 hr.)
- Charge for each service
- Treating physician
- Service code (CPT or HCPCS) and description of service $_____
- Diagnosis or symptoms

❑ **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. This nurse's statement must include: $_____
- Patient's name
- Date(s) of service
- Hours and shift for each service
- Diagnosis
- Dates of admission & discharge
- Nurse's name, license number and R.N. or L.P.N. designation $_____
- Charge for each service
- Name of hospital
- Nurse's signature

❑ **Hospital Services:** Attach itemized statements and/or bills. $_____

❑ **Other Services Specifically Included in Your Benefits Plan:** Please refer to your benefits 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:** _____/_____/_____

Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a claim containing any false, incomplete or misleading information may be guilty of a felony.

INSTRUCTIONS

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 received by no later than two years (24 months) 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.**

When filing a claim, please:

1. 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.

2. Submit a separate claim form for each family member for whom you are making a claim.

3. Attach itemized statements and bills that have been completed by professional medical sources.

   - 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.

   - A service code is required on many statements/bills. A service code means either a CPT, HCPCS or other medical code that describes the service.

4. If submitting a claim for reimbursement of certain over-the-counter (OTC) drugs*, please include the following with each claim:

   - A **valid** prescription from a physician for each new OTC drug or refill is required with each claim submitted. A copy of the prescription can be submitted for up to one year from the date it was written for most OTC drugs; however, a **new**, valid prescription is required for every nicotine replacement therapy claim. (Please note that the prescription can include multiple items such as the patch and lozenges, and that all covered items in the prescription will be reimbursed.)

   - Receipts for each OTC drug identifying the drug, dosage (if appropriate), and the amount paid. Please check when you receive the receipt for the OTC drug to be sure the drug name on the original prescription matches the one on the receipt.

5. For services received outside the United States, please submit an *International Claim Form* to the BlueCard® Worldwide Service Center. To download the form, visit the Members portal of **highmarkbcbsde.com**, click *Download a Form*, then select *International Claim*.

6. Mail completed forms and itemized bills to: Highmark Blue Cross Blue Shield Delaware
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   Wilmington, DE 19899-8831

** Please note the Customer Claim Form should be used to request reimbursement OTC drugs in the following situations:*

- *If a member has pharmacy benefits through Highmark Delaware and the benefits are not indicated on the ID card (and he/she does* **not** *have a separate prescription drug card).*
- *If a member has a separate ID card for prescription drugs, and receives drug coverage through a separate pharmacy benefits manager (PBM), but the PBM will* ***not*** *process OTC drug coverage.*

Did you remember to:

- *Attach your receipts*
- *Indicate the diagnosis*
- *Submit your valid prescription for OTC drugs*
- *Date this claim form*
- *Sign this claim form*

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