MEMBER-SUBMITTED MEDICAL CLAIM FORM FOR MEDICARE ADVANTAGE MEMBERS

Capital

When to use this form

Use this form to request payment or reimbursement if you received medical services or supplies under your medical plan from an out-of-network provider (one that doesn't have a contract with Capital Blue Cross ("Capital") or another Blue Plan). To find out if your provider has a contract with Capital, you can use the "Find a doctor" tool at **CapitalBlueMedicare.com**.

Note: In-network providers must submit claims for payment directly to Capital for you. If you use an in-network provider, you do not need to use this form to request payment or reimbursement.

This form **is not** for dental, vision, or pharmacy claims—you can find claim forms for these services at **CapitalBlueMedicare.com**.

Submit a separate form for each claim. A claim means the costs for a service and/or supply provided by a *single provider*, even if they were provided on different days.

What you'll need

In addition to the information requested in the form, you'll need to submit a detailed bill from your provider. To help us process your claim without delay, ask your provider to give you a detailed bill that includes **all** of the following:

- ✓ Provider's name and address.
- ✓ Your full name.
- ✓ Date each service/supply was provided.
- ✓ Where services/supplies were provided (e.g., home, office, hospital, laboratory, other).
- ✓ Procedure code for each unit or service **and** how many were provided (e.g., office visit, X-ray, lab).
- ✓ Diagnosis code (e.g., code for chest pains, broken bone, and sinusitis).
- ✓ Amount you paid to the provider (if payment was made).
- ✓ Amount charged by the provider for each service or supply.

If the bill contains incorrect or missing information, it will delay the processing of your claim. Please check your bill to be sure it contains all of this information, and if it does not, ask the provider for anything missing.

How to submit the completed claim form

Mail: Type your answers and print the form, or print the form and handprint your responses using blue or black ink—sign it—and mail the form with the bill and any related documents to:

Capital Blue Cross
PO Box 772402
Harrisburg, PA 17177-2402

What happens next?

We'll contact you if information is missing from your claim form or the provider's bill. If everything is in order, we'll process the claim. After it's processed, we'll send you an explanation of benefits (EOB) showing how your benefits applied to the claim. If money is due to you under your plan's benefits, we'll send you a check.

Your responsibility

If you receive a check from us after your claim is processed, it is your responsibility to pay the provider any amount still owed on the provider's bill.

Questions

If you have questions about this form or your benefits, please call the Member Services number on the back of your ID card.

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Please type or handprint answers.

YOUR INFORMATION

Name (first, middle initial, last): _____

Address

Street: _____

City: _____ State: _____ ZIP: _____

ID number (from Capital Blue Cross ID card)

Date of birth (MM/DD/YYYY)

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If you received an Explanation of Medicare Benefits (EOMB) that relates to this claim, please submit it with this claim form.

PROVIDER INFORMATION (Contact your provider for this information, or ask your provider to complete this section for you.)

Name of provider (first, last): _____

Provider's address

Street: _____

City: _____ State: _____ ZIP: _____

Provider National Provider Identifier (NPI) number: _____

Group/facility/other name: _____

Provider Tax ID number: _____

Address where services were provided

Street: _____

City: _____ State: _____ ZIP: _____

Provider phone number: _____

ACCIDENT INFORMATION (Required if an accident caused this medical expense.)

Was the medical expense incurred because of an accident?

☐ Yes ☐ No

Date of accident: (MM/DD/YYYY) _____ **Type of accident:** (Work/Auto/Other) _____

How did the accident happen?

OTHER INSURANCE (Required if the patient has health insurance coverage in addition to Capital coverage.)

Does the patient have other health insurance?

☐ Yes ☐ No

Insurance company name: _____

Policyholder name: _____

Policy/ID number: | | | | | | | | | | | | | | |

Group number (if applicable): | | | | | | | | | | | |

Policy start date (MM/DD/YYYY): _____

Policy end date (MM/DD/YYYY) (if applicable): _____

Please review your completed form to be sure nothing was missed. Failure to provide required information will delay processing your claim.

I attest that all information provided in support of this claim is true and correct. I acknowledge and understand that "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."

Policyholder's signature: _____ Date:____ /____ /_____

If submitting on behalf of the policyholder: If you are a personal representative submitting this form on behalf of the policyholder, be sure that Capital has a legally valid document (such as a power of attorney) on file giving you authority to act for the policyholder. If we do not, please submit the appropriate documentation with the claim form. You can find an Appointment of Representative form at **CapitalBlueMedicare.com**.

Personal representative name (please type or print): _____

Personal representative signature: _____ Date:____ /____ /_____

Email address:_____

Phone: _____ Second phone:_____

By providing a telephone number and/or an email address, I agree that Capital Blue Cross, its affiliates, subsidiaries, and/or agents may communicate with me by phone, text, or email for transactional, informational, or marketing purposes, including calls and messages made using an automatic telephone dialing system or pre-recorded voice messages. I understand my consent is not a condition of purchasing any goods or services

Healthcare benefit programs issued or administered by Capital Blue Cross and/or its subsidiaries, Capital Advantage Insurance Company®, Capital Advantage Assurance Company®, and Keystone Health Plan® Central. Independent licensees of the Blue Cross Blue Shield Association. Communications issued by Capital Blue Cross in its capacity as administrator of programs and provider relations for all companies.