Dear Member:

We will make every effort to process your claim promptly and accurately. However, we need your assistance to ensure that the information you send us is complete. Please read the following instructions and complete the claim form which is attached.

A description of the expenses which are covered by your program is contained in your certificate of coverage.

**INSTRUCTIONS**

1. Please separate all receipts for each family member. A separate claim form is needed for each person.

2. Receipts must include:
   - NAME AND ADDRESS (on letterhead stationery) of person, facility, or other provider of service or supply (hospital, doctor, medical center, etc.)
   - WHERE services were provided
   - Patient's full NAME
   - TYPE OF SERVICE or supply (doctor's office visit, nursing services, etc.)
   - A DESCRIPTION OR PROCEDURE CODE for each service
   - DATE each service or supply was provided
   - DIAGNOSIS, ILLNESS, OR INJURY for each service
   - AMOUNT CHARGED for each service or supply
   - NUMBER OF UNITS

Additional information—Claims for certain services may require you or the provider to submit additional information, such as:
   - Ambulance: The point of origin and destination of ambulance (from home to hospital, etc.)
   - Anesthesia: Length of time patient was under anesthesia and specific type of surgery for which anesthesia was given
   - Blood: Number of pints received, charge for each pint, and the number of pints replaced by donor(s)
   - Private Duty Nursing: Certification from doctor concerning medical necessity for the services; location of services (hospital, home, etc.); the hours or shifts worked; nurse's name and professional status (R.N., L.P.N., etc.); and the nurse’s registration or license number
   - Medical Documentation: May include physician notes and treatment plans

The following are not acceptable: cash register receipts, cancelled checks, money order receipts, personal lists or statements of payment on account. Since we keep all information you send us, you may want to make copies for your records.

3. When sending receipts, please circle only the services or supplies you are claiming. If you have already received payment or rejection notices related to these services from a primary insurance carrier, please attach them to the corresponding receipts to expedite processing. These notices are usually called “Explanation of Benefits,” or “Summary of Benefits.”

4. Preauthorization may be required for inpatient admissions and other selected procedures, including Home Medical Equipment, mental health, and substance abuse. Other services may require the submission of a treatment plan after a specified number of visits. For more information about the preauthorization process and program requirements, please refer to your certificate of coverage or call our Customer Service Department.

5. Please detach at perforation and mail the claim form to:

   Capital BlueCross
   P.O. Box 211457
   EAGAN, MN 55121-3057

6. If you have any questions about this claim form, please write to the address above or call 1.800.962.2242.
The numbered areas on this page explain more fully the corresponding questions on the claim form. It is important to print clearly on the claim form.

1. Patient/Member Information: Complete this section using the information on the patient’s/member’s identification card.

2. Subscriber Information: This section should be completed even if the patient and the subscriber are the same. The term ‘subscriber’ means the person whose employment or other status, except for family dependency, is the basis for coverage eligibility.

3. This section refers to the conditions or ailments that require the services to be obtained.

<table>
<thead>
<tr>
<th>Acceptable</th>
<th>Not Acceptable</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Diabetes John Doe, M.D. 01/01/2015</td>
<td>A. Laboratory Test 01/02/2015</td>
</tr>
<tr>
<td>B. Asthma John Smith, D.O. 03/25/2015</td>
<td>B. See Attached ———</td>
</tr>
</tbody>
</table>

4. If other members of the family were involved in this accident, write their names on the back of the claim form. If Workers’ Compensation rejected your claim, please send a copy of the rejection letter with this claim form. If this question does not apply, please check “No” on the top line.

5. MEDICARE: This question should be answered regardless of age. Check “Yes” or “No.” If yes, give effective date of enrollment (from Medicare ID Card). Please send itemized receipts along with the Explanation of Benefits Summary from Medicare.

6. If the patient has other coverage, check “Yes” and provide the information requested. Please send itemized receipts along with payment or rejection notices from the other insurance company. If other coverage does not apply, please check “No.”

7. Please be sure to sign the claim form and attach copies of your itemized receipt or billing statement.
**CLAIM FORM**

### 1. 
**PATIENT/MEMBER NAME**  
**ID NUMBER**  
**GROUP NUMBER**  

<table>
<thead>
<tr>
<th>Date of Birth (MO, DAY, YR)</th>
<th>Gender</th>
<th>Relationship to Subscriber</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>□ Male</td>
<td>□ Self</td>
</tr>
<tr>
<td></td>
<td></td>
<td>□ Spouse</td>
</tr>
<tr>
<td></td>
<td></td>
<td>□ Child</td>
</tr>
<tr>
<td></td>
<td></td>
<td>□ Other</td>
</tr>
</tbody>
</table>

**SUBSCRIBER NAME**  
**DATE OF BIRTH (MO, DAY, YR)**  
**EMPLOYEE STATUS**

<table>
<thead>
<tr>
<th></th>
<th>□ Active</th>
<th>□ Retired</th>
<th>□ Disabled</th>
<th>□ Other</th>
</tr>
</thead>
</table>

**PRESENT ADDRESS**  
**CITY**  
**STATE**  
**ZIP CODE**

### 2. 
**DESCRIBE CONDITIONS FOR WHICH YOU ARE REQUESTING BENEFITS AT THIS TIME:**

<table>
<thead>
<tr>
<th>Type of Injury or Illness</th>
<th>Name &amp; Degree of Doctor Treating Illness</th>
<th>Date First Treated</th>
</tr>
</thead>
<tbody>
<tr>
<td>A.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>B.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Use other side if needed)

### 3. 
**WERE EXPENSES DUE TO AN ACCIDENTAL INJURY?**

<table>
<thead>
<tr>
<th></th>
<th>□ Yes</th>
<th>□ No</th>
</tr>
</thead>
</table>

**A. Date of accident (MO, DAY, YR)**  
**Place/Type of Incident:**

- □ Home  
- □ Work  
- □ School  
- □ Auto  
- □ Motorcycle  
- □ Other

**B. Give a brief description of the incident**

### 4. 
**MEDICARE:**

- Is the patient entitled to benefits under Medicare Hospital Insurance (Part A)?
  - □ Yes  
  - □ No  
  - Effective Date: ______________________

- Is patient entitled to benefits under Medicare Medical Insurance (Part B)?
  - □ Yes  
  - □ No  
  - Effective Date: ______________________

**Health insurance number from Medicare ID Card**

### 5. 
**Are you submitting expenses incurred for Medical Emergency treatment received in a foreign country?**

<table>
<thead>
<tr>
<th></th>
<th>□ Yes</th>
<th>□ No</th>
</tr>
</thead>
</table>

**Description of Medical Emergency:**

### 6. 
**OTHER COVERAGE:**

- Does patient have additional/other health insurance coverage?  
  - □ Yes  
  - □ No  
  - (If “Yes,” complete below.)

<table>
<thead>
<tr>
<th>Insured’s Name</th>
<th>Employer’s Name</th>
<th>Insurance Company’s Name</th>
<th>Policy/Identification No.</th>
<th>Effective Date</th>
<th>Cancellation Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- Employment Status of Insured:
  - □ Active  
  - □ Retired  
  - □ Disabled

- Type of Coverage
  - □ Family  
  - □ Single  
  - □ Husband & Wife  
  - □ Parent & Child  
  - □ Parent & Children

- Type of Health Insurance
  - □ Hospital  
  - □ Medical/Surgical  
  - □ Major Medical  
  - □ Comprehensive Major Medical  
  - □ HMO  
  - □ Drug  
  - □ Dental  
  - □ Vision  
  - □ Point-of-Service (POS)  
  - □ Preferred Provider Organization (PPO)  
  - □ Other

**I verify that the information given above, in support of this claim, is true and correct.**

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.

- **Member Signature**  
- **Date**  
- **(Area Code) Home Phone**  
- **(Area Code) Work Phone**

*DO NOT STAPLE ANYTHING TO THIS FORM*
Examples of ACCEPTABLE AND NONACCEPTABLE Doctor Receipts

Capital BlueCross
P.O. Box 211457
EAGAN, MN 55121-3057

Acceptable

Anytown, U.S.A.
March 2, 2015
John Doe, M.D.

To Richard Doe:

02/02/2015  Office visit–cold  $20.00
02/10/2015  Office visit–cold  $20.00
02/28/2015  Home–virus infect.  $25.00

$65.00

List Additional Information Below

Not Acceptable

Anytown, U.S.A.

John Doe, M.D.

To Richard Doe:

Professional service rendered  $65.00

Missing: Dates, types of services, and amount charged for each service.