

Hospital Indemnity Plan Claim Form



A separate claim must be submitted for each patient when sending bills.

INSURED'S INFORMATION (as it appears on your Blue Cross and Blue Shield of Kansas identification card)

Member's name _____ Identification No. _____
Last First MI

Member's Address _____ Group No. _____
Street (if applicable)

_____ Date of Birth _____
City State ZIP Mo. / Day / Year

Is the above a change of address? Yes No

PATIENT'S INFORMATION

Patient's name _____ Date of Birth _____
Last First MI Mo. / Day / Year

Address _____
Street Male Female

City State ZIP

Relationship to Member Self Spouse Child Other

Nature of Illness _____

Diagnosis _____

Does this claim include Intensive Care Unit (ICU) or CardioCare Unit (CCU) services? Yes No

If yes, please indicate service dates: From _____ Thru _____ Number of days in ICU/CCU _____

Is claim a result of an accidental injury? Yes No Accident date _____

Date of service on bills submitted. Earliest date _____ Last date _____

REPORT OF SERVICES (attach itemized bill)

| Date of service | Place of service (use codes below) | Description of surgical or medical services received |
|-----------------|---------------------------------------|--|
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| | | |

O-Doctor's Office H-Patient's Home IN-Inpatient hospital OH-Outpatient Hospital EC-Extended Care Facility OL-Other Location

Were any of the hospital stays listed above in a skilled nursing or rehabilitation hospital? Yes No

Were any of the services in the above hospital stays for:

- Acupuncture Yes No
- Sexual Misfunctions Yes No
- Nervous and Mental Conditions Yes No
- Dental Care Yes No
- Convalescent Care Yes No

Please turn over

GENERAL INFORMATION

All claims need to be submitted within one (1) year and ninety (90) days of the date from which your services were received. To speed the processing of your claim, you should file once every three (3) months. A new claim form will be sent to you when any claims payment is made.

Preparation of bills

All hospital bills must be itemized and attached to the claim form.

Note: Cancelled checks, payment receipts or balance forward bills are not acceptable.

Preparation of claim form**Insured Information** *(things to remember)*

1. The **full** first name, last name and middle initial **MUST** be entered. The correct and complete identification number (and group number if applicable) **MUST** be entered for the claim to be processed.
2. The correct and complete address **MUST** be entered for mailing of payment.

Patient Information *(things to remember)*

1. Enter **full** name of patient, patient's date of birth and be sure to check a "Relationship to Member" block.

Note: All items must be completed for this claim to be processed.

Mailing Address

To ensure proper handling, mail this claim to:

Blue Cross and Blue Shield of Kansas
1133 SW Topeka Boulevard
Topeka, Kansas 66629-0001

Customer Service

Our customer service center personnel are available to answer your questions at:

In Topeka 291-4180 or
Toll Free 1-800-432-3990.

AUTHORIZATION TO RELEASE INFORMATION

I certify the information on this form is correct and that I am claiming benefits only for the charges attached.

Patient's signature **X** _____ Date _____
(or Parent/Guardian, if minor)