HEALTHSELECT OF TEXAS℠

**COMPREHENSIVE CLAIM FORM FOR BENEFITS**

BlueCross BlueShield of Texas

**Please submit your claim(s) with original bill(s) you received from the Provider or with the Provider's original signature on the attached bill(s).**

| | | |
|---|---|---|
| 1. NAME OF SUBSCRIBER (Employee or Retiree) | PATIENT'S NAME | |
| STREET | GROUP NUMBER **38000** | SUBSCRIBER IDENTIFICATION (AS SHOWN ON YOUR IDENTIFICATION CARD) |
| CITY | SEX ☐ MALE ☐ FEMALE | PATIENT'S RELATIONSHIP TO SUBSCRIBER 1. ☐ SELF 2. ☐ SPOUSE 3. ☐ CHILD 4. ☐ OTHER (Explain) |
| STATE ZIP CODE | PATIENT'S DATE OF BIRTH MUST BE ACCURATE THIS IS PART OF IDENTIFICATION | _____/_____/_____ Month Date Year |

2. DESCRIBE THE ILLNESS OR INJURY REQUIRING TREATMENT _____

_____

3. WAS TREATMENT RESULT OF (ENTER EITHER 1,2, OR 3) ☐ INJURY (DATE OF ACCIDENT) OR ILLNESS (DATE OF FIRST SYMPTOM) OR PREGNANCY (DATE OF CONCEPTION) SHOW DATE: _____ /_____ /_____ Month Day Year

4. IF INJURY, WAS MOTOR VEHICLE INVOLVED? ☐ YES ☐ NO

WAS ILLNESS OR INJURY WORK CONNECTED? ☐ YES ☐ NO NAME AND ADDRESS OF EMPLOYER

5. IS PATIENT COVERED UNDER ANY OTHER HEALTH BENEFITS PLAN HELD BY REASON OF LAW OR EMPLOYMENT? ☐ YES ☐ NO
(IF "YES" COMPLETE THE REMAINDER OF THIS SECTION)

NAME OF INSURING CO _____ ADDRESS _____

NAME OF POLICY HOLDER _____ BIRTH DATE _____ /_____ /_____ SEX ☐ MALE ☐ FEMALE
MONTH DAY YEAR

EMPLOYER'S NAME_____ EFFECTIVE DATE OF COVERAGE _____/_____/_____
MONTH DAY YEAR

6. TO BE COMPLETED REGARDLESS OF AGE OF PATIENT (SEE REVERSE SIDE FOR INSTRUCTIONS)

IS THE PATIENT ENTITLED TO BENEFITS UNDER MEDICARE HOSPITAL INSURANCE (PART A)? ☐ YES EFF _____ /_____ /_____ ☐ NO
MONTH DAY YEAR

IS THE PATIENT ENTITLED TO BENEFITS UNDER MEDICARE MEDICAL INSURANCE (PART B)? ☐ YES EFF _____ /_____ /_____ ☐ NO
MONTH DAY YEAR

IF "YES" GIVE PATIENT'S IDENTIFICATION # (FROM MEDICARE ID CARD) _____

7. I CERTIFY THE ABOVE IS COMPLETE AND CORRECT AND THAT I AM CLAIMING BENEFITS ONLY FOR CHARGES INCURRED BY THE PATIENT NAMED ABOVE.

Authorization is hereby given to any hospital, physician, or other Provider or other provider which participated in any way in my care and treatment to release to the Blue Cross and Blue Shield of Texas Plan which the Plans in their judgment deem necessary to the adjudication of this claim.

_____ _____ _____
Signature of Insured (Employee or Retiree) | Date | Telephone Number

Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

**ITEMIZED BILL(S) FOR COVERED SERVICES AND SUPPLIES MUST BE ATTACHED**

**SEE INSTRUCTIONS ON REVERSE SIDE AND REFER TO THE CLAIMS FILING INSTRUCTIONS IN THE BENEFIT BOOKLET**

**Please submit your claim(s) with original bill(s) you received from the Provider or with the Provider's original signature on the attached bill(s).**

**Blue Cross and Blue Shield of Texas**
P.O. Box 660044
Dallas, TX 75266-0044
1-800-252-8039

1081.020-302

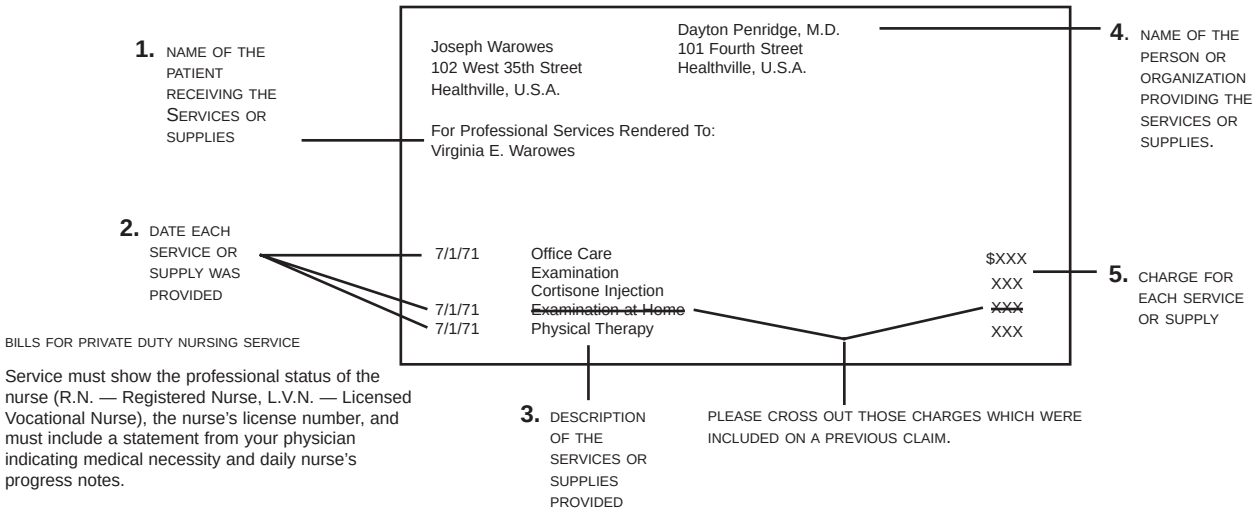
## INSTRUCTIONS

**IMPORTANT: DO NOT FILE THIS FORM IF YOUR PHYSICIAN IS SUBMITTING HIS CHARGES TO BLUE CROSS AND BLUE SHIELD.**

## PLEASE COMPLETE EVERY ITEM ON CLAIM FORM.

| | | |
|---|---|---|
| **1.** | SUBSCRIBER'S NAME AND ADDRESS | Please show the subscriber's name exactly as it appears on the Blue Cross and Blue Shield Identification card and specify the current address including the ZIP code. |
| | PATIENT'S NAME | Use patient's full name. No nicknames, please. |
| | FROM IDENTIFICATION CARD | Insert identification number as shown on your recent identification card. |
| | PATIENT'S SEX, RELATIONSHIP OF PATIENT TO SUBSCRIBER | Check appropriate box in each block. If "OTHER" box is checked — Please explain relationship of PATIENT to subscriber. |
| | BIRTHDATE | Show patient's date of birth. |
| 2. | DIAGNOSIS OR SYMPTOMS OF ILLNESS OR INJURY | A brief description will suffice. |
| 3. | TREATMENT (INJURY, ILLNESS, PREGNANCY) | Enter either a 1,2, or 3 for appropriate treatment in box and specify Date of Injury (accident), Date of Illness, or Pregnancy (date of conception). |
| 4. | IF INJURY | Give answer to question regarding motor vehicle. |
| | IF ILLNESS OR INJURY IS IN ANY WAY WORK CONNECTED | Check appropriate box and enter name and address of employer. |
| 5. | OTHER GROUP INSURANCE | Please check appropriate box. If "yes," complete the required information. |
| 6. | ALL OR PART OF CHARGES COVERED BY GOVERNMENT PROGRAM | Specify "yes" or "no" if you are covered under Medicare. If "yes," show effective date and give Medicare identification number. MEDICARE ENROLLEES SHOULD INCLUDE A COPY(S) OF THE MEDICARE EXPLANATION OF BENEFITS FORM(S) (EOB) WITH THEIR ITEMIZED STATEMENTS. |
| 7. | SUBSCRIBER'S SIGNATURE, DATE AND TELEPHONE NUMBER | Please sign and date this form and attach your physician's itemized letterhead statement(s). The itemized statement(s) should contain: |

Itemized Bills Cannot Be Returned




THIS COMPLETED FORM, TOGETHER WITH THE ITEMIZED BILLS SHOULD BE SUBMITTED TO:

**Blue Cross and Blue Shield of Texas**
P.O. Box 660044
Dallas, TX 75266-0044
1-800-252-8039

**For additional copies of this form call the Customer Service number listed above, or download the form from the ERS website at www.ers.state.tx.us**