# **MEDICAL EXPENSE**

Signature of Insured member or patient

# Claim Form and Instructions – ME/RE



Patient's Name (Siew Name, Name) Name)										Bli	ue Cross and Blue	Shield Association.
Patient's date of birth (MANDDYYYY)	1. PATIENT INFORMATION											
Name of Insured Member (2004 Name, Family Warre)  Insured's date of birth (MADDDYYYY)  Patient's Relationship to Insured's Self Spouse  Self Spouse  Child  Name of Plan Program Sponsor  Insured's current mailing address  Insured's current mailing address  Member Phone Number	Group ID Please enter the 12-digit	t Group IE	number as	shown	on card							
Name of Insured Member (Given Neme), Family Name)   Insured's date of birth (MMEDDYYYY)   Policy or Insured's current mailing address   Self   Spouse   Orbid	Patient's Name (Given Name, Family Name)			Pat	tient's dat	e of birth	n (MM/DD/YYYY	)	Patient's Ger	ıder		
Name of Plan Program Sporsor									Male	Fe	male	
Insured's current mailing address   Insured's current mailing address   Member Phone Number	Name of Insured Member (Given Name, Family Name)				Insured's date of birth (MM/DD/YYYY)				Patient's Relationship to Insured			
Member Email  Member Email  Member Phone Number    Member Phone Number									Self	Spouse	Cł	nild
Second Process   Seco	Name of Plan Program Sponsor			Ins								
Second Process   Seco												
Step patient covered under other health insurance company	Member Email							Member Pho	one Number			
Step patient covered under other health insurance company												
Step patient covered under other health insurance company	2. OTHER HEALTH INSURANCE											
Name and address of other insurance company  Policy Holder's Date of Birth (MMDDYYYY)  Policy or identification number of other coverage  Effective Date (MMDDYYYY)  Policy or identification number of other coverage  Effective Date (MMDDYYYY)  S. DIAGNOSIS — describe Illness, Injury or symptoms requiring treatment  IF IN AN ACCIDENT  Date of Doctor/Hospital Visit (MMDDYYYY)  Date of Doctor/Hospital Visit (MMDDYYYY)  Poscription/Details of Injury (attach additional roles if necessary)  If SIGNNESSILLNESS  Onset Date of Symptoms (MMDDYYY)  Description/Details of Illness (attach additional noise if necessary)  4. CHARGES — use a separate line to list each type of service or provider and attach itemized bills for all services  Name, City & Country of provider making charge  Diagnosis  Description of service (Diffice Visit, X-ray, Prescription, etc.)  Dates of Services  Charges (Plassar militaria)  Charges (		insurance	e?		YES	NO		If YES please complete this section				
Policy Holder's Date of Birth (MM/DD/YYYY)  3. DIAGNOSIS — describe illness, injury or symptoms requiring treatment  IF IN AN ACCIDENT  Date of Accident (MM/DD/YYYY)  Place of Accident (MM/DD/YYYY)  Place of Accident (MM/DD/YYYY)  Place of Accident (MM/DD/YYYY)  Date of Doctor/Hospital Visit (MM/DD/YYYY)  Bescription/Details of Injury (addited additional notes if necessary)  IF SICKNESS/ILLNESS  Onset Date of Symptoms (MM/DD/YYYY)  Date of Doctor/Hospital Visit (MM/DD/YYYY)  Place of Accident (MM/DD/YYYY)  Date of Doctor/Hospital Visit (MM/DD/YYYY)  Place of Accident (MM/DD/YYYY)  IF SICKNESS/ILLNESS  Onset Date of Symptoms (MM/DD/YYYY)  Date of Doctor/Hospital Visit (MM/DD/YYYY)  Accident additional notes if necessary)  If YES, when was the last occurrence and/or doctor/hospital Visit?  One of Description of Service (MM/DD/YYYY)  Accident (MM/DD/YYYY)  If YES, when was the last occurrence and/or doctor/hospital Visit?  One of Doctor/Hospital Visit (MM/DD/YYYY)  Accident (MM/DD/YYYY)  Accident (MM/DD/YYYY)  Place of Doctor/Hospital Visit (MM/DD/YYYY)  Accident (MM/DD/YYYY)  Accident (MM/DD/YYYY)  If YES, when was the last occurrence and/or doctor/hospital Visit?  One of Doctor/Hospital Visit (MM/DD/YYYY)  Accident (MM/DD/YYYY)  Accident (MM/DD/YYYY)  Accident (MM/DD/YYYY)  Place of Doctor/Hospital Visit (MM/DD/YYYY)  Accident (MM/DD/YYYY)  Accident (MM/DD/YYYY)  Place of Doctor/Hospital Visit (MM/DD/YYYY)  Accident (MM/DD/YYYY)  Accident (MM/DD/YYYY)  Place of Doctor/Hospital Visit (MM/DD/YYYY)  Accident (MM/DD/YYY												
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3. DIAGNOSIS - describe illness, injury or symptoms requiring treatment  Te IN AN ACCIDENT  Date of Accident (MMDD/YYYY)  Date of Doctor/Hospital Visit (MMDD/YYYY)  Description/Details of Injury a nesult of participation in an Intercollegiate Sport?  Was the injury a nesult of participation in an Intercollegiate Sport?  Place of Accident (MMDD/YYYY)  Description/Details of Injury (MMDD/YYYY)  Description/Details of Injury)  Place of Doctor/Hospital Visit (MMDD/YYYY)  Description/Details of Injury)  Place of Doctor/Hospital Visit (MMDD/YYYY)  Date of Doctor/Hospital Visit (MMDD/YYYY)  Have you had this Sickness/illness  YES NO If YES, when was the last occurrence and/or doctor/hospital visit?  Description/Details of Illness (ration additional notes in necessary)  A. C-HARGES - use a separate line to list each type of service or provider and attach itemized bills for all services  Name, City & Country of provider making charge  Diagnosis  Description of service (Office Visit, X-ray, Prescription, etc.)  Dates of Service (Place of Service (MMDD/YYYY)  S. CLAIM PAYMENT REIMBURSEMENT  Make payment to the provider  If payment is to be paid to the provider, please ensure bank information is on the provider invoice  Make payment to Primary Insured  Reimbursement Method:  Bank Wire Transfer (complete below)  Who pasible, ullifolity is bank accuse is recommended to acid unrecessary feet by the receiving tank. Us bank accuses by visit will be originally alway and the plant of the provider interediary Bank Account Number  Bank Address - City & Country  Currency of Reimbursement  Bank Sort Tode  Bank WiFT Code Number (Policyholder)  Bank Sort Tode  Bank Sort Tode  Intermediary Bank Account Number  Litermediary Bank Details (If Applicable)  Name of Intermediary Bank Account Number  Intermediary Bank Details (If Applicable)  Name of Intermediary Bank Details (If Applicable)	Ballia Haldada Bata af Bidh aman paga	0.0	. 12 2 . 1 1	· · · · · · · · · · · · · · · · · · ·			Effective Date		Termination Date			
Place of Accident (MMDDYYYY)	Policy Holder's Date of Birth (MM/DD/YYY	Y) PC	Policy or identification number of				coverage					
Place of Accident (MMDDYYYY)												
Date of Doctor/Hospital Visit   Was the injury a result of participation   YES   NO   Was this an Auto Accident?   YES   NO	3. DIAGNOSIS – describe illness, injury or symptoms requiring treatment											
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In an Intercollegiate Sport?   NO   Was this an Auto Accident?   NO	Date of Accident (MM/DD/YYYY)	Pla			ace of Accident							
F SICKNES/ILLNESS									Was this an Auto Accident?			
Onset Date of Symptoms (MMDD/YYY) Have you had this Sickness/Illness before?  YES NO If YES, when was the last occurrence and/or doctor/hospital visit?  Description/Details of Illness (attach additional notes if necessary)  4. CHARGES – use a separate line to list each type of service or provider and attach itemized bills for all services  Name, City & Country of provider making charge  Diagnosis  Description of service (Office Visit, X-ray, Prescription, etc.)  Dates of Service (Please indicate currency)  5. CLAIM PAYMENT REIMBURSEMENT  Make payment to the provider Reimbursement Method:  US Dollar Check  Bank Wire Transfer (complete below)  When possible, utilizing US bank accounts is recommended to avoid unnecessary fees by the receiving bank. U.S. bank accounts (only) wires will be completed via ACH which generally eliminates or reduces wire transaction fees.  Account Holder's Name – Must be Principal Member (Policyholder)  Bank Address – City & Country  Currency of Reimbursement  Bank 9-digit ABA Number – US Banks  Bank 8 or 11-digit SWIFT Code – NON-US Banks  Bank Account Number  Our Provider of Reimbursement  Intermediary Bank Details (If Applicable)  Intermedia												
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recognizing that applicable law concerning personal information may differ among countries. Please see the back of this form for important information.	any way in the patient's care, to release to GeoBlue and its business associates in any country any medical or other personal information that they deem necessary to provide service or adjudicate this claim,											

Date

## FRAUD NOTICE

### General Fraud Warning -

Any person who knowingly and with intent to defraud, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

#### **AUTHORIZATION FOR ASSIGNMENT**

## Authorization for Assignment -

All payments will be made to the Primary Insured if the doctor/hospital bills have been paid by you. If you would like a third party to receive reimbursement for covered expenses under this policy, you must request an Authorization for Assignment from GeoBlue Member Services.

Authorization for Assignment of Benefits is voluntary. Any documentation accompanying a payment or otherwise could contain federal and/or state Protected Health Information and other protected private or financial information. Protected Health Information means health data that could be used to individually identify you including your name, address and specific medical material and facts.

#### **INSTRUCTIONS FOR FILING A CLAIM**

The following steps will assist you in filing claims. Please note that submitting an incomplete form will result in the delay of processing your claim.

## For Parts 1 – 4 of the claim form:

- Please submit a separate claim form for each patient
- Please be as descriptive as possible

Submitted bills must be **itemized** – canceled check, cash register receipts and non-itemized "balance due" statements **cannot be** processed.

- An Itemized bill is a full description of all actual charges and each itemized bill must include:
  - Name and address of provider (doctor, hospital, laboratory, ambulance service, etc.), name of patient, date(s) of service, amount charged for each service described, diagnosis or reason for treatment
- Submitted bills for Prescriptions should include the name of the drug, the quantity dispensed and the dosage.

## To accurately complete Part 5, Payment Details:

- Payments are made to the Primary Participant/Insured Member on the plan. Payments cannot be made directly to a dependent or to a third party (other than the medical provider).
- For payments made via wire transfer/ACH, the PrimaryParticipant/Insured Member must be listed as an account holder on the bank account receiving funds.
- If paying international provider, invoice must include bank information

SEND COMPLETED CLAIM FORMS, WRITTEN INQUIRIES AND ADDRESS CHANGES TO THE APPROPRIATE ADDRESS BELOW

GeoBlue
Claims Department
PO Box 1748
Southeastern, PA 19399-1748

Claims Submission Fax: 1.610.482.9623
Claims Submission Email: claims@geo-blue.com

24/7 Member Services: +1-610-263- 4660