



# BlueAdvantage

## Administrators of Arkansas

An Independent Licensee of the Blue Cross and Blue Shield Association

P.O. Box 1460  
Little Rock, Arkansas 72203-1460

A SEPARATE CLAIM FORM MUST BE SUBMITTED FOR EACH PATIENT WHEN SENDING BILLS TO  
BlueAdvantage Administrators of Arkansas

1. GROUP NUMBER & NAME _____		2. MEMBER ID NO. _____		
<b>PATIENT'S INFORMATION</b>	3. Patient's Last Name _____ Complete First Name _____ Initial _____		4. Date of Birth Mo. ____ Day ____ Yr. ____	
	5. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	6. Patient's Relationship to Employee <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other (Specify) _____		
	7. Diagnosis or Nature of Illness or Injury _____ _____ _____			
	Date Illness Began: Mo. ____ Day ____ Yr. ____			
	8. Was this an accident? <input type="checkbox"/> Yes <input type="checkbox"/> No	9. If yes, date of accident. Mo. ____ Day ____ Yr. ____	10. Was this an automobile accident? <input type="checkbox"/> Yes <input type="checkbox"/> No	11. Was the illness/accident related to employment? <input type="checkbox"/> Yes <input type="checkbox"/> No
	12. Is patient a full time student? <input type="checkbox"/> Yes <input type="checkbox"/> No	13. If yes, what school? _____		
<b>EMPLOYEE INFORMATION</b>	14. Employee Last Name _____ First Name _____ Initial _____		15. ASSIGNMENT: Payment for this claim should be made to:  <input type="checkbox"/> Hospital <input type="checkbox"/> Doctor <input type="checkbox"/> Employee	
	16. Employee Address  Street _____ City _____  State _____ Zip _____			
	I hereby authorize any insurance company, prepayment organization, employer, hospital, or physician, to release all information with respect to myself or any of my dependents which may have a bearing on the benefits payable under this or any other plan providing benefits or services. I certify that the above information in support of this claim is true and correct.			
<b>OTHER INSURANCE</b>	17. Do you have other health insurance with a <u>group</u> or <u>government program</u> ? <input type="checkbox"/> Yes (Please complete section below) <input type="checkbox"/> Yes, Medicare A (Please submit your "Explanation of Medicare Benefits" with these bills.) <input type="checkbox"/> No <input type="checkbox"/> Yes, Medicare B If Medicare, reason for coverage: <input type="checkbox"/> Over 65 <input type="checkbox"/> Disabled <input type="checkbox"/> Kidney Disease			
	18. Name of Insured _____		19. Name and Address of Insured's Employer _____	
	20. Name and address of other Insurance Company _____		21. Policy No. (other company) _____	
	22. Type of Coverage <input type="checkbox"/> Single <input type="checkbox"/> Family		Has other Insurance Company paid? <input type="checkbox"/> Yes If yes, please submit a copy of their payment with these bills. <input type="checkbox"/> No	

Date \_\_\_\_\_ Signature of Insured \_\_\_\_\_

## GENERAL INFORMATION

You should submit your bills in a timely manner. To speed the processing of your claim, all bills must be itemized and attached to the claim form. ALL items on the claim form must be completed to insure proper payment.

**NOTE:** CANCELLED CHECKS, PAYMENT RECEIPTS, OR BALANCE FORWARD BILLS ARE NOT ACCEPTABLE.

## HOW TO FILE A CLAIM

### 1. PREPARATION OF BILLS

#### A. Separate bills into the following groups:

- |                      |                                |                    |                    |                       |
|----------------------|--------------------------------|--------------------|--------------------|-----------------------|
| 1. Physician's Bills | 3. Drug Bills or Prescriptions | 4. Durable Medical | 5. Ambulance Bills | 7. Physical Therapy & |
| 2. Hospital Bills    | Drug Claim Forms               | Equipment Bills    | 6. Nurse's Bills   | Speech Therapy Bills  |
|                      |                                |                    |                    | 8. Other Bills        |

#### B. Check the bills for the following information:

- |   |   |
|---|---|
| 1. Physician's Bills - (Must be submitted on physician's Statement of Accounts or AMA approved uniform claim form showing physician's social security number or employer tax identification number.)<br>a. Full name of patient<br>b. Date(s) of service<br>c. Full description of the type of procedures, medical services or supplies furnished for each date<br>d. Amount charged for each service<br>e. Diagnosis | 5. Ambulance Bills - (Bills must be on ambulance firm's letterhead.)<br>a. Full name of patient<br>b. Mileage of trip<br>c. Charges per mile<br>d. Points of departure and mileage<br>e. Description of other services (i.e., oxygen, equipment, etc.)<br>f. Charge for each service<br>g. Total amount charged                                 |
| 2. Hospital Bills<br>a. Itemized statement from hospital, which must include diagnosis  | 6. Nurse's Bills - (Must have signature and registration or license number of R.N. or L.P.N.)<br>a. Full name of patient<br>b. Professional status (i.e., R.N. or L.P.N., etc.) of each service<br>c. Beginning and ending dates of the nursing service<br>d. Time & number of hours worked<br>e. Charge for nursing service<br>f. Nurse's name |
| 3. Drug Bills -<br>a. Full name of patient<br>b. Date(s) of purchase<br>c. Prescription number<br>d. Amount charged for each prescription<br>e. Name of drugs and diagnosis   | 7. Physical Therapy and Speech Therapy Bills - (Must be on therapist's stationery.)<br>a. Full name of patient<br>b. Date(s) of service<br>c. Charge for each service<br>d. Name of licensed therapist<br>e. Must have appropriate evaluation forms submitted with bills  |
| 4. Durable Medical Equipment Bills - (Bill must include an invoice from the supplying firm.) NOTE: On purchase of equipment, you must receive prior approval to be eligible for payment.<br>a. Full name of patient<br>b. Date(s) of services<br>c. Description of items<br>d. Charge for each item<br>e. Must have supporting statement from physician.  | 8. Other Bills - (Must include an invoice from the person or organization who provided the services.)<br>a. Name of the person or organization who provided the services<br>b. Full name of patient<br>c. Date the service was provided<br>d. Description of services<br>e. Charge for each service   |

### 2. PREPARATION OF CLAIM FORM

#### A. Patient Information (things to remember)

1. Enter FULL name of patient; patient's date of birth (month, day and year), and be sure to check the relationship to block.

#### B. Employee Information (things to remember)

1. You must enter FULL first and last name, middle initial.
2. You must enter the correct and complete Member Identification number before this claim can be processed.
3. You must enter the correct and complete address for mailing of payment.