



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. \_\_\_\_\_

PATIENT'S INFORMATION

3. Patient's Last Name \_\_\_\_\_ Complete First Name \_\_\_\_\_ Initial \_\_\_\_\_ 4. Date of Birth  
 Mo. \_\_\_\_ Day \_\_\_\_ Yr. \_\_\_\_

5. Sex  Male  Female 6. Patient's Relationship to Employee  
 Self  Spouse  Child  Other (Specify) \_\_\_\_\_

7. Diagnosis or Nature of Illness or Injury  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Date Illness Began: Mo. \_\_\_\_ Day \_\_\_\_ Yr. \_\_\_\_

8. Was this an accident?  Yes  No 9. If yes, date of accident.  
 Mo. \_\_\_\_ Day \_\_\_\_ Yr. \_\_\_\_ 10. Was this an automobile  
 accident?  Yes  No 11. Was the illness/accident  
 related to employment?  Yes  No

12. Is patient a full time student?  Yes  No 13. If yes, what school?  
 \_\_\_\_\_

EMPLOYEE INFORMATION

14. Employee Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Initial \_\_\_\_\_ 15. ASSIGNMENT:  
 Payment for this claim should be made  
 to:  
 Hospital  Doctor  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.

OTHER INSURANCE

17. Do you have other health insurance with a group or government program?  
 Yes (Please complete section below)  Yes, Medicare A (Please submit your "Explanation of  
 Medicare Benefits" with these bills.)  
 No  Yes, Medicare B  
 If Medicare, reason for coverage:  Over 65  Disabled  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  Single  Family Has other Insurance Company paid?  
 Yes If yes, please submit a copy of their payment with these bills.  
 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 Social Security number before this claim can be processed.
3. You must enter the correct and complete address for mailing of payment.