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. _____

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)
☐ No
☐ Yes, Medicare A
☐ Yes, Medicare B
(Please submit your "Explanation of Medicare Benefits" with these bills.)
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
   2. Hospital Bills
   3. Drug Bills or Prescriptions Drug Claim Forms
   4. Durable Medical Equipment Bills
   5. Ambulance Bills
   6. Nurse's Bills
   7. Physical Therapy & 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.)
      a. Full name of patient
      b. Date(s) of service
      c. Full description of the type of procedures, medical services or supplies furnished for each date
      d. Amount charged for each service
      e. Diagnosis
   2. Hospital Bills
      a. Itemized statement from hospital, which must include diagnosis
   3. Drug Bills -
      a. Full name of patient
      b . Date(s) of purchase
      c. Prescription number
      d. Amount charged for each prescription
      e. Name of drugs and diagnosis
   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.
      a. Full name of patient
      b. Date(s) of services
      c. Description of items
      d. Charge for each item
      e. Must have supporting statement from physician.
   5. Ambulance Bills - (Bills must be on ambulance firm's letterhead.)
      a. Full name of patient
      b. Mileage of trip
      c. Charges per mile
      d. Points of departure and mileage
      e. Description of other services (i.e., oxygen, equipment, etc.)
      f. Charge for each service
      g. Total amount charged
   6. Nurse's Bills - (Must have signature and registration or license number of R.N. or L.P.N.)
      a. Full name of patient
      b. Professional status (i.e., R.N. or L.P.N., etc.) of each service
      c. Beginning and ending dates of the nursing service
      d. Time & number of hours worked
      e. Charge for nursing service
      f. Nurse's name
   7. Physical Therapy and Speech Therapy Bills - (Must be on therapist's stationery.)
      a. Full name of patient
      b. Date(s) of service
      c. Charge for each service
      d. Name of licensed therapist
      e. Must have appropriate evaluation forms submitted with bills
   8. Other Bills - (Must include an invoice from the person or organization who provided the services.)
      a. Name of the person or organization who provided the services
      b. Full name of patient
      c. Date the service was provided
      d. Description of services
      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.

NON-DISCRIMINATION AND LANGUAGE ASSISTANCE NOTICE

NOTICE: Our Company complies with applicable federal and state civil rights laws and does not discriminate, exclude, or treat people differently on the basis of race, color, national origin, age, disability, or sex.

We provide free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters, written information in various formats (large print, audio, accessible electronic formats, other formats), and language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. **If you need these services, contact our Civil Rights Coordinator.**

If you believe that we have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Civil Rights Coordinator
601 Gaines Street, Little Rock, AR 72201
Phone: 1-844-662-2276; TDD: 1-844-662-2275

You can file a grievance in person, by mail, or by email. If you need help filing a grievance our Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201
Phone: 1-800-368-1019; TDD: 1-800-537-7697

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

ATTENTION: Language assistance services, free of charge, are available to you. Call 1-844-662-2276.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-844-662-2276.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-844-662-2276.

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-844-662-2276.

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-844-662-2276 번으로 전화해 주십시오.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-844-662-2276.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-844-662-2276.

ملاحظة: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. إتصل بالرقم 1-844-662-2276.

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-844-662-2276.

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-844-662-2276.

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-844-662-2276.

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-844-662-2276.

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-844-662-2276.

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-844-662-2276 まで、お電話にてご連絡ください。

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-844-662-2276.

توجه: اگر به زبان فارسی صحبت می‌کنید، خدمات و کمک‌های زبانی رایگان برای شما موجود است. برای کسب اطلاعات بیشتر، با شماره 1-844-662-2276 تماس بگیرید.

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-844-662-2276.

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-844-662-2276 पर कॉल करें।

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-844-662-2276.

انتباہ: اگر آپ اردو بولتے ہیں تو، آپ کے لئے زبان کی مدد کی خدمات بلا معاوضہ دستیاب ہیں۔ 1-844-662-2276 پر کال کریں۔

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-844-662-2276.

LALE: Ñe kwōj kōnono Kajin Ṃajōḷ, kwomaroñ bōk jerbal in jipañ ilo kajin ṇe aṃ ejjeḷọk wōṇāān. Kaalọk 1-844-662-2276.