Hospital Indemnity Plan Claim Form

A separate claim form must be submitted for each patient when sending bills.

BlueCross BlueShield of Kansas
bcbsks.com

Section 1 – Member Information (as it appears on your BCBSKS identification card)

RESET FORM

First Name ____ MI ____ Date of Birth ____ ____ ____

Last Name ____ Suffix ____ Member ID Number ____

Street Address ____ Group Number ____

City ____ Is the above a change of address? ☐ Yes ☐ No

State ____ ZIP Code ____ +4 ____

Section 2 – Patient Information

First Name ____ MI ____

Last Name ____ Suffix ____

Street Address ____

City ____

State ____ ZIP Code ____ +4 ____

Gender ☐ Male ☐ Female ____ ____ ____ Date of Birth

Relationship to Member: ☐ Self ☐ Spouse ☐ Child ☐ Other

Does this claim include Intensive Care Unit (ICU) or CardioCare Unit (CCU) services? ☐ Yes ☐ No

If yes, please indicate service dates:

____ ____ ____ From ____ ____ ____ Through

Number of days in ICU/CCU ____

Nature of illness:

Diagnosis:

Is this claim the result of an accidental injury? ☐ Yes ☐ No

If yes, give date of accident: ____ ____ ____ Date of Accident

Please give date of service on bills submitted:

____ ____ ____ Earliest Date ____ ____ ____ Last Date

Section 3 – Report of Services (attach itemized bill)

Date of service	Place of service (use codes below)	Description of surgical or medical services received

O – Doctor's office ; H – Patient's Home ; IN – Inpatient Hospital ; OH – Outpatient Hospital ;
EC – Extended Care Facility ; OL – Other Location

Please continue on the next page.

Section 3 – Report of Services (continued)

Were any of these hospital stays in a skilled nursing or rehabilitation hospital? ☐ Yes ☐ No

Were any of the services in the above hospital stays for:

Acupuncture? ☐ Yes ☐ No

Dental care? ☐ Yes ☐ No

Sexual misfunctions? ☐ Yes ☐ No

Convalescent care? ☐ Yes ☐ No

Nervous and mental conditions? ☐ Yes ☐ No

For contract purposes, has the patient received evaluation, treatment, prescription refills, or any medical treatment in the last year (365 days) by any provider? ☐ Yes ☐ No

If yes, please indicate dates, diagnosis and provider information below:

Date of occurrence(s)	Diagnosis	Performing/Prescribing Provider Name and Address

Section 4 – General Information

All claims need to be submitted within one (1) year and ninety (90) days of the date from which your services were received. To speed the processing of your claim, you should file once every three (3) months. A new claim form will be sent to you when any claims payment is made.

Preparation of bills

All hospital bills must be itemized and attached to the claim form. *Note:* Cancelled checks, payment receipts or balance forward bills are not acceptable.

Preparation of claim form

Member Information: Things to remember:

- The full first name, last name and middle initial MUST be entered. The correct and complete identification number (and group number, if applicable) MUST be entered for the claim to be processed.
- The correct and complete address MUST be entered for mailing of payment.

Patient Information: Things to remember

- Enter full name of patient, patient's date of birth and be sure to check a "Relationship to Member" block.

Note: All items must be completed for this claim to be processed.

Mailing Address

To ensure proper handling, mail this claim to:
Blue Cross and Blue Shield of Kansas
1133 SW Topeka Boulevard
Topeka, KS 66629-0001

Customer Service

Our customer service center personnel are available to answer your questions at:
In Topeka: 291-4180
Toll-Free: 1-800-432-3990

Section 5 – Authorization to Release Information

I represent that all statements made herein are complete and true to the best of my knowledge. I understand that if I fail to provide any material information or if I misrepresent any material fact, such omission or misrepresentation may result in the re-rating, termination or rescission of my health care coverage and/or criminal prosecution.

Your signature required

_____ ____ ____ _____

Applicant (Signature of parent/guardian if other than applicant) Date Signed

_____

Print Name