

Health Insurance Claim

**UNITED**



**BlueCross BlueShield**

Send claim to:  
BlueCross BlueShield  
P.O. Box 805107  
Chicago, IL 60680-4112

**Filing  
Claims**  
... can be easy  
as **1-2-3**

**MOST HOSPITALS  
AND DOCTORS WILL  
FILE A CLAIM DIRECTLY  
WITH US.**

Please show your Blue Cross and Blue Shield identification card to the hospital or doctor.

If you are filing a claim, please fill out the reverse side of this form. Help us avoid unnecessary delays by answering all questions completely.

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A Division of Health Care Service Corporation, a Mutual Legal Reserve Company,  
an Independent Licensee of the Blue Cross and Blue Shield Association

Help us process your claims quickly...

# **INSIST ON ITEMIZED BILLS**

We want to process your claims quickly, but we can't do so without properly itemized bills.

**HERE'S WHAT WE URGE YOU TO DO:**

1. Show the following instructions to the persons providing for your health care and ask them for bills that follow these instructions.
2. We recommend that you make copies of each bill for your personal records and send the original. **The original bills will not be returned.**

**IS MEDICARE YOUR PRIMARY HEALTH INSURANCE PAYER?**

If YES, please be sure to send all bills to Medicare FIRST\*. After you receive an "EXPLANATION OF BENEFITS" form from Medicare showing what was paid, send it along with your medical bills and a completed claim form to us.

**Itemized Bills For Medical Treatment Or Surgery Should Show:**

- Physician's name, address and phone number.
- Physician's tax identification number.
- Full name of patient, not just name of person to whom bill is addressed.
- Place where service was received (hospital, office or clinic).
- Diagnosis of illness or injury. If an injury give the date it happened.
- Description of service received.
- Date of each treatment or surgical procedure.
- Charge for each treatment or surgical procedure.

\*Services not covered by Medicare may be sent directly to Blue Cross and Blue Shield FIRST

**Pharmacist Bills Should Show:**

- Name and address of pharmacy.
- Full name of patient, not just name of person responsible for payment.
- Date(s) of purchase(s).
- Prescription number(s) and name of drug(s) purchased.
- Diagnosis
- Separate charge for each prescription.
- Computerized listings must have the pharmacist's signature (or rubber stamp) and license number on each page.

The pharmacist must give you bills with itemized charges plainly written on each bill.

**IMPORTANT: CASH REGISTER/CREDIT CARD receipts or LISTINGS made by you of drugs purchased CANNOT BE USED.**

**Helpful Hints:**

- **When you receive services from a PPO physician or hospital, you do not need to pay up-front or file a claim form. Your provider will file a claim on your behalf.**
- Benefits will be paid directly to the hospital for hospital confinement, and to all PPO Providers even if you pay up front.
- Documents will not be returned. Keep copies of all bills and explanations of benefits for your records.
- COBRA Insurance payments should be mailed directly to: ADP  
P.O. Box 78343  
Phoenix, AZ 85062-8343

**You may copy this form for future use.**



**HEALTH INSURANCE CLAIM FORM**

Send Completed Claim Form To:  
Blue Cross and Blue Shield  
PO Box 805107  
Chicago, IL 60680-4112



If you have any questions on how to complete this form, call: 1-800-5-FLY-UAL (1-800-535-9825)

NOTICE TO ALL PARTIES COMPLETING THIS FORM: It is fraudulent to fill out this form with information you know to be false or to omit important facts. Criminal and/or civil penalties can result from such acts. **You do not need to file a claim form when you receive services from a PPO physician or hospital. Your provider will file a claim on your behalf.**

PLEASE PRINT OR TYPE CLEARLY

**PATIENT INFORMATION** — A separate claim form must be completed for each family member.

PATIENT'S FULL LEGAL NAME (Last, First, Middle Initial)		SEX:	DATE OF BIRTH		
		<input type="checkbox"/> Male <input type="checkbox"/> Female	Month	Day	Year
PATIENT IS: <input type="checkbox"/> Member <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Retiree OTHER, please explain relationship:					
IF CLAIM IS FOR CHILD 22 OR OLDER—IS CHILD: A full time student? <input type="checkbox"/> Yes <input type="checkbox"/> No Disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No					

**PAYEE** — Indicate how payment is to be made.

MAKE PAYMENT TO **PROVIDER** (hospital, doctor, etc.)  MAKE PAYMENT TO **MEMBER**, provider has been paid

I authorize payment to be made directly to provider: \_\_\_\_\_  
Signature

**IDENTIFICATION NUMBER** — Copy this from your Blue Cross and Blue Shield Identification Card.

GROUP NUMBER: \_\_\_\_\_ **FILE NUMBER UAL:** \_\_\_\_\_

**MEMBER INFORMATION**

MEMBER NAME: (As shown on your Blue Cross and Blue Shield ID Card)	DATE OF BIRTH	HOME PHONE:
	Month   Day   Year	(____)____-____

**CLAIM INFORMATION**

IS THIS A JOB RELATED INJURY (WORKERS COMPENSATION CLAIM)?  Yes  No IF YES, DATE OF ACCIDENT: \_\_\_\_\_

DOES THIS CLAIM INCLUDE PRESCRIPTION DRUGS?  Yes  No IF YES, PLEASE INDICATE THE DIAGNOSIS ON THE NEXT LINE.

DIAGNOSIS: \_\_\_\_\_  
\_\_\_\_\_

**OTHER INSURANCE INFORMATION**

Are there any OTHER medical benefits available to you, your spouse, or your dependents from OTHER Group Insurance, including OTHER Blue Cross and Blue Shield policies, OTHER Employer, Labor or Professional Organizations, Medicare, etc.?  
 Yes (provide below)  No DOES SPOUSE WORK FOR UNITED? IF YES, FILE# \_\_\_\_\_

POLICY HOLDER NAME:	SOCIAL SECURITY NUMBER:	
	____/____/____	
POLICY HOLDER IS: <input type="checkbox"/> Member <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> OTHER, please explain relationship:		
INSURANCE CARRIER NAME:	POLICY NUMBER:	EFFECTIVE DATE:
ADDRESS:		PHONE NUMBER:
		(____)____-____

**RELEASE OF INFORMATION:** I certify that the above information is correct and that the bills attached were incurred by the patient listed above. I authorize any medical professional, hospital, medical or medically related facility, pharmacy, government agency, insurance company, or other person or firm to provide Blue Cross and Blue Shield information, including copies or records, concerning advice, care or treatment provided the patient above including, without limitation, information relating to mental illness, use of drugs or alcohol, upon presentation of the original copy of this signed authorization. I understand that such information will be used by Blue Cross and Blue Shield for the purpose of evaluating a claim for insurance benefits for services provided to the patient named above. I understand that I or any authorized representative will receive a copy of this authorization upon request. The authorization is valid from the date signed for the duration of the claim.

Sign Here \_\_\_\_\_ Date \_\_\_\_\_  
Signature of Member