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HOW TO COMPLETE YOUR Out-of-Network Claim Form



An Independent Licensee of the Blue Cross and Blue Shield Association



Get Your Out-of-Network Claim Processed Faster

Did you recently see a provider out of your plan's network? Start by checking your benefits book to make sure you have out-of-network coverage. If you submit an out-of-network claim form, it's important that Blue Cross Blue Shield of Arizona (BCBSAZ) receives key pieces of information from you to process your claim.



As you complete the form, you'll want to have your member ID card and the itemized statement from your provider handy.

REMEMBER

Out-of-network claims must be submitted within one year of the date of service to be eligible for benefit.



Your Personal Information and Insurance Policy Details

The key to getting your claim processed is providing accurate and complete information on your claim form. The top half of the claim form covers your personal information and your insurance coverage. Have your member ID card nearby.

HEALTH INSURANCE CLAIM FORM
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCCI) 02/12

CARRIER (vertical label on the right)

PATIENT AND INSURED INFORMATION (vertical label on the right)

LINE 1a points to: 1a. INSURED'S ID NUMBER (For Program in Item 1)

LINE 2 points to: 2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

LINE 3 points to: 3. PATIENT'S BIRTH DATE

LINE 4 points to: 4. INSURED'S NAME (Last Name, First Name, Middle Initial)

LINE 6 points to: 6. PATIENT-RELATIONSHIP TO INSURED

LINE 11 points to: 11. INSURED'S POLICY GROUP OR FECA NUMBER

LINE 11a points to: a. INSURED'S DATE OF BIRTH

Insured's name (LINE 4)
ID number (LINE 1a)

Eastern Illinois University
Member Name: JOHN DOE
Group No: 033104
Dependent(s) Name: JANE RAYMOND LUCY
Member ID: XBM01246978
Card Print Date: 9/30/16

PPO

Group number (LINE 11)

The key items on the form that MUST be completed are:

- LINE 1a** The insured's ID number (Member ID on your ID card)
- LINE 2** The patient's first and last name
- LINE 3** The patient's birthdate
- LINE 4** The insured's name (Member Name on your ID card)
- LINE 6** The patient's relationship to the insured
- LINE 11** The insured's policy group number (Group No. on your ID card)
- LINE 11a** The insured's birthdate

That's it for this part of the form!

Your Provider and Diagnosis Information

The bottom half of the claim form requests information about your provider and your illness or injury. An itemized statement from your provider will be key to filling out this information. If you have a question about your statement and how to use it to fill out this part of the form, contact your provider.

LINE 17	14. DATE OF CURRENT ILLNESS, INJURY OR PREGNANCY (LMP) MM : DD : YY QUAL :		15. OTHER DATE QUAL : MM : DD : YY		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM : DD : YY TO MM : DD : YY						
	17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		17a. :	17b. NPI :	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM : DD : YY TO MM : DD : YY						
LINE 21	19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)				20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO						
	21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. :				22. RESUBMISSION CODE ORIGINAL REF. NO.						
LINE 24a	24. A. DATE(S) OF SERVICE		B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)	E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. EPSTDY FAMILY PLAN	I. ID. QUAL	J. RENDERING PROVIDER ID. #
	MM	DD	YY	MM	DD	YY					NPI
	1										NPI
	2										NPI
	3										NPI
	4										NPI
	5										NPI
6										NPI	
LINE 25	25. FEDERAL TAX I.D. NUMBER		SSN <input type="checkbox"/>	EIN <input type="checkbox"/>	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? <small>(patient claim, not cash)</small> <input type="checkbox"/> YES <input type="checkbox"/> NO	28. TOTAL CHARGE \$	29. AMOUNT PAID \$	30. Rsvd for NUCC Use		
	31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE OR CREDENTIALS				32. SERVICE FACILITY LOCATION INFORMATION		33. BILLING PROVIDER INFO & PHONE # ()				
LINE 28											

The key items on the form that MUST be completed are:

- LINE 17** The name of your provider
- LINE 21** Your diagnosis—this will be a code (found on the statement from your provider). If there were multiple diagnoses, there are multiple codes.
- LINE 24a** Date of service—This is the date(s) you saw your provider.
- LINE 25** Your provider's tax ID number (found on the statement)
- LINE 28** Total charges (found on the statement)

That's it for this part of the form!



THAT'S IT!

Before submitting your form, double check that you have filled in these key pieces of information.

To submit your form, mail it to:

BLUE CROSS BLUE SHIELD OF ARIZONA
P.O. BOX 13466
PHOENIX AZ 85002-3466

If we have any questions about your form, we'll contact you. Once your claim has been processed, you will receive an Explanation of Benefits confirming the claim was processed and what out-of-network benefit applies.

Blue Cross Blue Shield of Arizona (BCBSAZ) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. BCBSAZ provides appropriate free aids and services, such as qualified interpreters and written information in other formats, to people with disabilities to communicate effectively with us. BCBSAZ also provides free 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, call (602) 864-4884 for Spanish and 1 (877) 475-4799 for all other languages and other aids and services.

If you believe that BCBSAZ has 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: BCBSAZ's Civil Rights Coordinator, Attn: Civil Rights Coordinator, Blue Cross Blue Shield of Arizona, P.O. Box 13466, Phoenix, AZ 85002-3466, (602) 864-2288, TTY/TDD (602) 864-4823, crc@azblue.com. You can file a grievance in person or by mail or email. If you need help filing a grievance, BCBSAZ's 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, 1 (800) 368-1019, 1 (800) 537-7697 (TDD). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

QUESTIONS?

If you need additional help completing this form,
please call the number on the back of your ID card.



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HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

PICA

1. MEDICARE <i>(Medicare#)</i>	MEDICAID <i>(Medicaid#)</i>	TRICARE <i>(ID# / DoD#)</i>	CHAMPVA <i>(Member ID#)</i>	GROUP HEALTH PLAN <i>(ID#)</i>	FECA BLK LUNG <i>(ID#)</i>	OTHER <i>(ID#)</i>	1a. INSURED'S ID NUMBER <small>(For Program in Item 1)</small>				
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)				3. PATIENT'S BIRTH DATE MM DD YY M F		4. INSURED'S NAME (Last Name, First Name, Middle Initial)					
5. PATIENT'S ADDRESS (No., Street)				6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other		7. INSURED'S ADDRESS (No., Street)					
CITY		STATE		8. RESERVED FOR NUCC USE			CITY		STATE		
ZIP CODE		TELEPHONE (Include Area Code) ()					ZIP CODE		TELEPHONE (Include Area Code) ()		
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)				10. IS PATIENT'S CONDITION RELATED TO:		11. INSURED'S POLICY GROUP OR FECA NUMBER					
a. OTHER INSURED'S POLICY OR GROUP NUMBER				a. EMPLOYMENT? (Current or Previous) YES NO		a. INSURED'S DATE OF BIRTH MM DD YY M F					
b. RESERVED FOR NUCC USE				b. AUTO ACCIDENT? PLACE (State) YES NO		b. OTHER CLAIM ID (Designated by NUCC)					
c. RESERVED FOR NUCC USE				c. OTHER ACCIDENT? YES NO		c. INSURANCE PLAN NAME OR PROGRAM NAME					
d. INSURANCE PLAN NAME OR PROGRAM NAME				10d. CLAIM CODES (Designated by NUCC)		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO <i>If yes, complete items 9, 9a, and 9d.</i>					
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.							12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.		
SIGNED _____							DATE _____		SIGNED _____		
14. DATE OF CURRENT ILLNESS, INJURY OR PREGNANCY (LMP) MM DD YY QUAL				15. OTHER DATE QUAL MM DD YY		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY					
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE				17a. _____ 17b. NPI		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY					
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)						20. OUTSIDE LAB? \$ CHARGES YES NO			22. RESUBMISSION CODE ORIGINAL REF. NO.		
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) A. _____ B. _____ C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____						ICD Ind.		23. PRIOR AUTHORIZATION NUMBER			
24. A. DATE(S) OF SERVICE FROM MM DD YY TO MM DD YY		B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER		E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. EPSDT FAMILY PLAN	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1									NPI		
2									NPI		
3									NPI		
4									NPI		
5									NPI		
6									NPI		
25. FEDERAL TAX I.D. NUMBER SSN EIN			26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO		28. TOTAL CHARGE \$		29. AMOUNT PAID \$	30. Rsvd for NUCC Use	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)				32. SERVICE FACILITY LOCATION INFORMATION				33. BILLING PROVIDER INFO & PHONE # ()			
SIGNED _____ DATE _____				a. _____		b. _____		a. _____		b. _____	

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

CARRIER

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND TRICARE PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or TRICARE participation cases, the physician agrees to accept the charge determination of the Medicare carrier or TRICARE fiscal intermediary as the full charge and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or TRICARE fiscal intermediary if this is less than the charge submitted. TAICARE is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, TRICARE, FECA AND BLACK LUNG)

In submitting this claim for payment from federal funds, I certify that: 1) the information on this form is true, accurate and complete; 2) I have familiarized myself with all applicable laws, regulations, and program instructions, which are available from the Medicare contractor; 3) I have provided or will provide sufficient information required to allow the government to make an informed eligibility and payment decision; 4) this claim, whether submitted by me or on my behalf by my designated billing company, complies with all applicable Medicare and/or Medicaid laws, regulations, and program instructions for payment including but not limited to the Federal anti-kickback statute and Physician Self-Referral law (commonly known as Stark law); 5) the services on this form were medically necessary and personally furnished by me or were furnished incident to my professional service by my employee under my direct supervision, except as otherwise expressly permitted by Medicare or TRICARE; 6) for each service rendered incident to my professional service, the identity (legal name and NPI, license #, or SSN) of the primary individual rendering each service is reported in the designated section. For services to be considered "incident to" a physician's professional services, 1) they must be rendered under the physician's direct supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of non-physicians must be included on the physician's bills.

For TRICARE claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, TRICARE, FECA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)

We are authorized by CMS, TRICARE and OWCP to ask you for information needed in the administration of the Medicare, TRICARE, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101; 41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, "Carrier Medicare Claims Record," published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR TRICARE CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under TRICARE/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of TRICARE.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to Individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1197. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PAA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. This address is for comments and/or suggestions only. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.