Hospital Indemnity Plan Claim Form

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

bcbsks.com

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

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

This information is being furnished in compliance with applicable federal regulations.

This Notice has important information. This notice has important information about your application or coverage through Blue Cross and Blue Shield of Kansas. Look for key dates in this notice. You may need to take action by certain deadlines to keep your health coverage or help with costs. You have the right to get this information and help in your language at no cost. Please call 1-800-432-3990.

Discrimination is against the law.

Blue Cross and Blue Shield of Kansas (BCBSKS) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. BCBSKS does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Blue Cross and Blue Shield of Kansas:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Holly Graves.

If you believe that BCBSKS 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:

Holly Graves, Director, Individual Sales and Customer Service, 1133 S.W. Topeka Blvd., Topeka, KS 66629-0001,
1-800-432-3990, TTY: 1-800-766-3777, Fax: 785-290-0711, CSC@bcbsks.com.

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Holly Graves 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, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

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

Para obtener asistencia en español, llame al servicio de atención al cliente al número que aparece en su tarjeta de identificación.

請撥打您 ID 卡上的客服號碼以尋求中文協助。

Gọi số dịch vụ khách hàng trên thẻ ID của quý vị để được hỗ trợ bằng Tiếng Việt.

한국어로 도움을 받고 싶으시면 ID 카드에 있는 고객 서비스 전화번호로 문의해 주십시오.

Para sa tulong sa Tagalog, tumawag sa numero ng serbisyo sa customer na nasa inyong ID card.

Обратитесь по номеру телефона обслуживания клиентов, указанному на Вашей идентификационной карточке, для помощи на русском языке.

اتصل برقم خدمة العملاء الموجود على بطاقة هُويتك للحصول على المساعدة باللغة العربية.

Rele nimewo sèvis kliyantèl ki nan kat ID ou pou jwenn èd nan Kreyòl Ayisyen.

Pour une assistance en français du Canada, composez le numéro de téléphone du service à la clientèle figurant sur votre carte d'identification.

Ligue para o número de telefone de atendimento ao cliente exibido no seu cartão de identificação para obter ajuda em português.

Aby uzyskać pomoc w języku polskim, należy zadzwonić do działu obsługi klienta pod numer podany na identyfikatorze.

日本語でのサポートは、ID カードに記載のカスタマーサービス番号までお電話でお問い合わせください。

Per assistenza in italiano chiamate il numero del servizio clienti riportato nella vostra scheda identificativa.

Rufen Sie den Kundendienst unter der Nummer auf Ihrer ID-Karte an, um Hilfestellung in deutscher Sprache zu erhalten.

برای دریافت راهنمایی به زبان فارسی ، با شماره خدمات مشتری که بر روی کارت شناسایی شما درج شده است تماسبگیرید..