



BlueCross BlueShield of Central New York

An Independent Licensee of the Blue Cross and Blue Shield Association

P.O. Box 4979 • Syracuse, N.Y. 13221 • TDD (315)448-6764 • (315)448-4250 • N.Y.S. only 1-800-652-0092

SECTION ONE

Before signing claim form, please read the following.

Failure to submit a claim form without the information listed below will result in the claim being returned to you.

- In order for this claim to be processed an itemized bill **must** be attached and include:
 - The provider's name and address (hospital, Dr's, lab, pharmacy, etc.)
 - The date(s) of service
 - The patient's name
 - Charges listed for each service
 - The description of service
 - Prescription receipts must include the prescription number, physician and name
 - Diagnosis or symptoms
- If another insurance carrier or Medicare had made payment on this service, their explanation of benefits form must be attached.
- Only **one** patient may be included on a claim form.
- There is no limit to the amount of bills you may attach to the claim form.
- It is recommended that you keep copies of information submitted to Blue Cross and Blue Shield for your records.

CALL OUR 4YOU LINE FOR CLAIM FORMS, ADDRESS CHANGE, BENEFIT INFORMATION OR NEW I.D. CARD. DIAL (315)448-4968 or 1-800-752-6260.

SECTION TWO

1. Patient's Last Name		First	2. Patient's Date of Birth		3. Patient's Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	
4. Blue Cross and Blue Shield ID Number (include the three digit prefix on your card)			5. Total (Office use only)		6. Patient's Account Number (Office use only)	
7. Subscriber's (insured's) Complete Mailing Address				City	State	Zip
8. Subscriber's (insured's) Last Name			First	9. Was Condition Related to? Employment: <input type="checkbox"/> Yes <input type="checkbox"/> No Auto Accident: <input type="checkbox"/> Yes <input type="checkbox"/> No		
10. Has Bill Been Paid by You? <input type="checkbox"/> Yes <input type="checkbox"/> No		11. Group Number		12. Symptoms or Diagnosis		13. Date and Time Symptoms Started or Accident Occurred

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or furnishes for the purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such occasion.

Signature of Contract Holder: _____

Date: _____

SECTION THREE-FOR OFFICE USE ONLY

Total										COB		COB PD		Total										COB		COB PD	
P 1 Name					Type	Co	DX			P 2 Name					Type	Co	DX										
DATE	POS	TOS	PROC	M	MI	#SER	\$	ACT CODE		DATE	POS	TOS	PROC	M	MI	#SER	\$	ACT CODE									
1										1																	
2										2																	
3										3																	
4										4																	
5										5																	
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7										7																	
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12										12																	

HR _____ MV _____ Ref Phy _____ RCN _____