

Independence Administrators

Medical Claim Form

See the back of this form for instructions.
Please mail claims to the address on your
identification card.

1 - MEMBER /	Member's name (First, Middle, Last)		Identification #	Group #	
	Present address - Street <input type="checkbox"/> New address		City	State	
2 - OTHER INSURANCE	Patient's name (First, Middle, Last)		Patient's relationship to member <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Handicapped dependent <input type="checkbox"/> Other		
			Sex <input type="checkbox"/> M <input type="checkbox"/> F	Birth date ____/____/____	
Does the patient have other health insurance coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, complete the rest of Section 2.					
3 - PATIENT'S CONDITION	Policyholder's name (First, Middle, Last)		Birth date ____/____/____	Policyholder's employment status <input type="checkbox"/> Active <input type="checkbox"/> Disabled <input type="checkbox"/> Retired <input type="checkbox"/> Effective date: ____/____/____	
	Policyholder's relationship to member <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other		Other insurance carrier's name	Identification #	
	Type(s) of coverage (Check all that apply.)		<input type="checkbox"/> Hospitalization <input type="checkbox"/> Medical-surgical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Drug <input type="checkbox"/> Major medical <input type="checkbox"/> Other (Specify.) _____		
	Contract covers <input type="checkbox"/> Policyholder only <input type="checkbox"/> Policyholder and spouse <input type="checkbox"/> Policyholder and child(ren) <input type="checkbox"/> Family		Effective date ____/____/____		
Is the patient entitled to benefits under Medicare Part A or B? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, complete the rest of Section 2.					
Medicare effective date ____/____/____ Medicare ID # _____					
Member's employment status <input type="checkbox"/> Active <input type="checkbox"/> Retired <input type="checkbox"/> Disabled					
a. Describe the conditions for which you are requesting coverage.					
Type of injury or illness		Name of doctor treating injury/illness		Date of first symptoms	
_____		_____		____/____/____	
_____		_____		____/____/____	
b. If this claim is the result of an injury, do you intend to file a claim against another individual, business, organization, or insurer for damages arising from the injury? <input type="checkbox"/> Yes <input type="checkbox"/> No					
c. If this claim is the result of an injury, have you retained an attorney to represent you? <input type="checkbox"/> Yes <input type="checkbox"/> No					
d. Were the services related to a hospitalization? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, complete the rest of Question 3d.					
Admission date ____/____/____		Discharge date ____/____/____			
Hospital name _____		Admitting physician _____			
e. Were the expenses due to an accident? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, complete the rest of Question 3e.					
Accident date ____/____/____		<input type="checkbox"/> Work <input type="checkbox"/> Auto <input type="checkbox"/> School <input type="checkbox"/> Other (Specify.) _____			
f. Is this claim for prescription drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, complete the rest of Question 3f.					
Pharmacy name _____		Address _____			
4 - AUTHORIZATION	I certify that the information provided on this claim form is correct and complete, and that I am claiming benefits actually incurred by the named patient. I authorize any hospital, physician, or other provider who participated in the care and treatment of the patient to release all medical or other information requested for the processing of the claim to Independence Administrators. I hereby agree to reimburse Independence Administrators in full if this claim is paid incorrectly. 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 conceals, for the purpose of misleading, information concerning any material fact thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.				
	MEMBER SIGNATURE _____		DATE _____	(AREA CODE) HOME PHONE _____	(AREA CODE) WORK _____

INSTRUCTIONS

Your provider may submit claims directly to Independence Administrators. You should submit this claim form only when your provider does not submit a claim for you.

1. Please attach itemized bills to this claim form. These bills should include the following information:
 - Name, address, and telephone number (on official bill head) of the **provider** who rendered the service or supplied the item
 - **patient's** full name
 - **description** of each service rendered or item supplied
 - **date and amount charged** for each service rendered or item supplied
 - **diagnosis** of the ailment
2. Please be sure that a **physician's medical certification** accompanies bills for purchase or rental of medical equipment
3. Please complete the claim form carefully, and be sure to include the information requested above. This will help avoid unnecessary delays in processing your claim.
4. You do not need to submit a claim form for prescription drug purchases made at network pharmacies. The pharmacist will file the claim for you. If you purchase your prescription at a non-network pharmacy, you may still be entitled to reimbursement for a portion of your prescription drug expenses by completing Section 3 of this claim form. Be sure to include itemized receipts for each prescription. Remember to ask your pharmacist for the NDC number of the drug you purchased, and record that number in Section 3 on the front of this form.

Your health benefits are entirely funded by your company. Independence Administrators provides administrative and claims payment services only.

Independence Administrators is an independent licensee of the Blue Cross and Blue Shield Association.