



**NEW JERSEY
STATE HEALTH BENEFITS PROGRAM**

NJ PLUS Claim Form

(PLEASE TYPE OR PRINT)

DO NOT WRITE ABOVE THIS LINE

I. MEMBER	1. MEMBER'S NAME (Last, First, Middle Initial)		2. MEMBER'S IDENTIFICATION NUMBER ALPHA-NUMERIC PORTION		
			PREFIX (Check One) <input type="checkbox"/> NJP <input type="checkbox"/> HHP <input type="checkbox"/> FLP		
	3. MEMBER'S ADDRESS (No., Street)		CITY	STATE	ZIP CODE
	4. TELEPHONE NUMBER (Include Area Code) ()	5. MEMBER'S STATUS <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Widowed	5a. EMPLOYMENT STATUS <input type="checkbox"/> Active <input type="checkbox"/> COBRA <input type="checkbox"/> Retired	5b. MEMBER'S BIRTH DATE Month Day Year ____/____/____	5c. MEMBER'S SEX <input type="checkbox"/> Male <input type="checkbox"/> Female
II. PATIENT	6. PATIENT'S NAME (Last, First, Middle Initial)		9. IS PATIENT'S CONDITION RELATED TO:		
	7. PATIENT'S BIRTH DATE Month Day Year ____/____/____		7a. PATIENT'S SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	8. PATIENT'S STATUS <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Widowed	
	10. PATIENT'S RELATIONSHIP TO MEMBER <input type="checkbox"/> Self <input type="checkbox"/> Spouse/ Domestic Partner <input type="checkbox"/> Child <input type="checkbox"/> Other		11. IS PATIENT EMPLOYED? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, LIST EMPLOYER: _____		
III. COORDINATION OF BENEFITS	12. IS PATIENT COVERED BY ANOTHER GROUP HEALTH PLAN, HMO, MEDICAID OR ANY OTHER FEDERAL, STATE OR GOVERNMENTAL AGENCY? <input type="checkbox"/> YES <input type="checkbox"/> NO If Yes, Complete Questions 12a through 12g		12a. DOES THE PATIENT HAVE: MEDICARE PART A? <input type="checkbox"/> NO <input type="checkbox"/> YES EFFECTIVE DATE: _____ MEDICARE PART B? <input type="checkbox"/> NO <input type="checkbox"/> YES EFFECTIVE DATE: _____ REASON FOR ENTITLEMENT? <input type="checkbox"/> AGE <input type="checkbox"/> DISABILITY <input type="checkbox"/> ESRD		
	12b. OTHER POLICYHOLDER'S NAME		12c. OTHER POLICYHOLDER'S EMPLOYMENT STATUS <input type="checkbox"/> Active <input type="checkbox"/> COBRA <input type="checkbox"/> Retired	12d. OTHER POLICYHOLDER'S DATE OF BIRTH Month Day Year ____/____/____	
	12e. OTHER HEALTH PLAN NAME		12f. OTHER HEALTH PLAN IDENTIFICATION NUMBER AND GROUP NUMBER		
	12g. OTHER HEALTH PLAN ADDRESS (No., Street)		CITY	STATE	ZIP CODE
IV. AUTHORIZATION	13. THE FOLLOWING AUTHORIZATION TO RELEASE INFORMATION MUST BE COMPLETED: For claim adjudication, analysis, and administration, I agree that New Jersey State auditors, NJ State Health Benefits Program and Horizon Blue Cross Blue Shield of New Jersey may see, or get a copy of, ALL RECORDS which pertain to claims I submit or incur for myself or my covered dependents under the New Jersey State Health Benefits NJ PLUS Plan. This information is for the sole use of New Jersey State to administer and analyze its health program, or Horizon Blue Cross Blue Shield of New Jersey, which will process the claim. Unless a law requires it, information will not be given in an identifiable form to any other persons unless I agree to its release in writing.				
	Signature of Patient (unless a minor)				Date
V. SIGNATURE	14. I the undersigned, authorize and request Horizon Blue Cross Blue Shield of New Jersey, to make payment for benefits which may be due herein to:				
	NAME OF HEALTH CARE PROFESSIONAL AND THEIR TAX OR SOCIAL SECURITY NUMBER		MEMBER'S SIGNATURE		DATE



Horizon Blue Cross Blue Shield of New Jersey is an Independent Licensee of the Blue Cross Blue Shield Association

PLEASE READ THIS IMPORTANT INFORMATION CAREFULLY

COORDINATION OF BENEFITS

If you or your dependent(s) are covered by another health insurance program, please complete the information requested in Section III.
Example: Spouse covered by another insurance company or other Horizon Blue Cross Blue Shield of New Jersey coverage.

When submitting charges for services or supplies that have been partially paid or declined by other group health insurance, including claims related to auto accidents, attach a copy of the Notice of Payment or Explanation of Benefits from the other health care insurer **along with itemized bill(s)**.

MEDICARE

If you or your dependent(s) are eligible for Medicare Benefits and Medicare is your primary insurer, be sure you include the Explanation of Medicare Benefits (EOMB) that was sent by Medicare explaining the charges paid or not paid.

If your EOMB has more than one page, send us copies of all pages.

CLAIM FORM WILL BE RETURNED TO YOU IF THIS ADDITIONAL INFORMATION IS NOT SUPPLIED

HELPFUL HINTS

When you are submitting expenses for more than one family member, please complete a separate claim form for each person. Itemized bills for covered services or supplies must be attached to the form and include the following:

Check that each itemized bill is legible and contains ALL of the following information:

- NAME & ADDRESS of Health Care Professional rendering the service or supplying the item
- HEALTH CARE PROFESSIONAL'S Federal Tax Identification Number
- PATIENT'S FULL NAME
- TYPE of service rendered or item supplied
- DATE each service rendered or item supplied
- AMOUNT charged for each service rendered or item supplied
- DIAGNOSIS

BILLS MISSING ANY OF THIS INFORMATION WILL DELAY PROCESSING AND MAY BE RETURNED TO YOU

Cash register receipts, cancelled checks, money order receipts, personal itemizations, and bills only noting a "balance due" are not acceptable.

If you have any questions about how to submit your Claims, please call the Customer Service # 1-800-414-SHBP (7427).

Please make copies of your bills for your records before you submit the original bills.

Prescription Drugs Bills must show the prescription number, name of drug and the name and address of the pharmacy.

Durable medical equipment? (Wheel chair, crutches, braces, oxygen, etc.) Your doctor's certification must be submitted indicating the expected length of time the equipment will be in use. If renting, please have your medical equipment supplier also indicate the purchase price of the equipment on the bill.

Foreign Claim? Bills for services incurred outside of the U.S. must include an English translation and the exchange rate at the time of services.

WHERE TO SUBMIT YOUR CLAIM FORMS

Please submit claims to the appropriate address based on the three letters that appear on your NJ PLUS ID card before your identification number - the alpha prefix is the indicator that determines where you should send your claims.

	MEDICAL CLAIMS	MENTAL HEALTH/SUBSTANCE ABUSE CLAIMS
NJP	Horizon Blue Cross Blue Shield of New Jersey P.O. Box 820 Newark, New Jersey 07101-0820	NJ PLUS 199 Pomeroy Road Parsippany, New Jersey 07054
HHP	Empire Blue Cross Blue Shield P.O. Box 5049 Middletown, New York 10940-5049	NJ PLUS 199 Pomeroy Road Parsippany, New Jersey 07054
FLP*	Blue Cross Blue Shield of Florida National Account Service Company P.O. Box 2988 Jacksonville, FL 32232	NJ PLUS 199 Pomeroy Road Parsippany, New Jersey 07054

***If your alpha prefix is FLP and Medicare is your primary coverage, send your medical claims to the New Jersey address.**

FRAUD WARNING

ANY PERSON WHO KNOWINGLY FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE OR MISLEADING INFORMATION IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES

TO REPORT SUSPECTED FRAUD CALL 1-800-624-2048 AT HORIZON BLUE CROSS BLUE SHIELD OF NEW JERSEY