NEW JERSEY
STATE HEALTH BENEFITS PROGRAM

Traditional Plan 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
PREFIX: **YHA** | ALPHA-NUMERIC PORTION: **3HZN**

3. MEMBER'S ADDRESS (No., Street) | CITY | STATE | ZIP CODE

4. TELEPHONE NUMBER (Include Area Code) (   )

5. MEMBER'S STATUS ☐ Single ☐ Divorced ☐ Married ☐ Widowed

5a. EMPLOYMENT STATUS ☐ Active ☐ COBRA ☐ Retired

5b. MEMBER'S BIRTH DATE Month ____ / Day ____ / Year ____

5c. MEMBER'S SEX ☐ Male ☐ Female

II. PATIENT

6. PATIENT'S NAME (Last, First, Middle Initial)

7. PATIENT'S BIRTH DATE Month ____ / Day ____ / Year ____

7a. PATIENT'S SEX ☐ Male ☐ Female

8. PATIENT'S STATUS ☐ Single ☐ Divorced ☐ Married ☐ Widowed

9. IS PATIENT'S CONDITION RELATED TO:
a. EMPLOYMENT? (Current or Previous) ☐ NO ☐ YES
b. AUTO ACCIDENT ☐ NO ☐ YES
c. OTHER ACCIDENT ☐ NO ☐ YES
d. DATE OF ACCIDENT ____ / ____ / ____
STATE IN WHICH AUTO ACCIDENT OCCURRED: ________

10. PATIENT'S RELATIONSHIP TO MEMBER ☐ Self ☐ Spouse/ Domestic Partner ☐ Child ☐ Other

11. IS PATIENT EMPLOYED? ☐ YES ☐ 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?
☐ YES ☐ NO If Yes, Complete Questions 12a through 12h

12a. DOES THE PATIENT HAVE:
MEDICARE PART A? ☐ NO ☐ YES EFFECTIVE DATE: ________
MEDICARE PART B? ☐ NO ☐ YES EFFECTIVE DATE: ________
REASON FOR ENTITLEMENT? ☐ AGE ☐ DISABILITY ☐ ESRD

12b. OTHER POLICYHOLDER'S NAME

12c. OTHER POLICYHOLDER'S EMPLOYMENT STATUS ☐ Active ☐ COBRA ☐ 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

12h. COMPLETE IF YOU DO NOT HAVE MEDICARE COVERAGE AND IF YOU CHECKED ACTIVE OR COBRA IN SECTION 5a.
IF YOU HAVE SINGLE COVERAGE ONLY, DID YOUR INCOME LAST YEAR (AS FILED ON IRS 1040 FORM) EXCEED $14,000? ☐ YES ☐ NO
IF "NO" PLEASE ATTACH COPY OF LAST YEAR'S IRS 1040 FORM.
IF YOU ARE COVERING DEPENDENTS, DID YOUR FAMILY INCOME LAST YEAR (AS FILED ON IRS 1040 FORM) EXCEED $20,000? ☐ YES ☐ NO
IF "NO" PLEASE ATTACH COPY OF LAST YEAR'S IRS 1040 FORM.

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 Traditional 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 ________

0704 (W0406)

SEE BACK OF THIS FORM FOR IMPORTANT INFORMATION

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

Horizon Blue Cross Blue Shield of New Jersey
P.O. Box 1609
Newark, New Jersey 07101-1609

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