Member Health Expense Report

Blue Cross Blue Shield of Georgia (BCBSGA)
P.O. Box 105370
Atlanta, GA 30348-5370
www.bcbsga.com

Please see instructions for filing on page two.

1

Member no.	Group no.	No. of items attached

2

SECTION 1: PATIENT INFORMATION — Person who received services

Last name	First name	M.I.

Sex	Relationship to member	Date of birth
☐ Male ☐ Female	☐ Self ☐ Spouse ☐ Child ☐ Other _____	

3

SECTION 2: PRIMARY MEMBER INFORMATION

Last name	First name	M.I.

Address	City	State	ZIP code

☐ IMPORTANT: Check here if this is a new address

4

SECTION 3: OTHER COVERAGE INFORMATION

Is this patient covered by any other group health care plan or Medicare? ..... ☐ Yes ☐ No
Was condition related to an automobile accident? ..... ☐ Yes ☐ No
Was condition related to employment? ..... ☐ Yes ☐ No

If "Yes" to either of these questions, please complete the following:

Policyholder's name	Policy no.	Date of birth

Insurance company's name	Please indicate type of coverage
	☐ Health ☐ Dental ☐ Vision ☐ Pharmacy

Insurance company's address	City	State	ZIP code

Employer's name	Group no.	Medicare no.	Medicare	Medicare effective date
			☐ Part A ☐ Part B	

5

SECTION 4: MEDICAL INFORMATION

Is this an	Date of injury
☐ Illness ☐ Injury If injury, date of injury is required.	

Describe the illness or injury which required treatment

How did the injury occur?

READ THIS: Any intentional false statement in this application or willful misrepresentation relative thereto is a violation of the law.

I authorize the release of any medical information necessary to process this claim and also certify that the above information is correct.

6

Patient or authorized person signature	Date
X	

Note: Please indicate the physician providing service on each bill. For questions, please call the number on the back of your ID card.

INSTRUCTIONS FOR COMPLETION OF THE MEMBER HEALTH EXPENSE REPORT

Blue Cross and Blue Shield of Georgia (BCBSGA)/Blue Cross Blue Shield Healthcare Plan of Georgia (BCBSHP) value your membership. The following tips are offered to ensure accurate and timely processing of your claim.

The instructions for completion of this Report are listed below, in sequence of the numeric order on the first page:

1
- Record the member and group number exactly as it appears on the member ID card.
- Indicate the total number of items attached to the report in the block provided.

2
- The patient is the person who received the health care services or supplies. The patient's name should be included on every statement filed, along with the date of service.
- Different claim forms must be filed for each patient/member. Indicate the patient's sex and relationship to the primary member and the patient's date of birth in the fields provided.

3
- The primary member is the employee insured by BCBSGA/BCBSHP. The primary member's name, current address, and ZIP code should be completed in this section. If the member has a new address, the change address box should be checked.

4
- If the patient has no other coverage, simply check "No."
- If the patient is covered by another group health insurance program or Medicare, check "Yes" and furnish the following: Policyholder's name, policy number, the insurance company's name and address, the policyholder's employer, and the insurance group number.
- If the patient is covered by Medicare, please enter the Medicare number and check the appropriate box for Part A and/or Part B, along with the effective date.
- If the patient is covered by another health insurance company or Medicare, the corresponding Explanation of Benefits must be attached. Failure to provide this information will delay the claim and require a request of additional information.

5
- Describe the illness or injury for which treatment was necessary. In the case of multiple illnesses, please indicate the diagnosis on each itemization attached. If the treatment was due to an injury, provide the date and details of how the accident occurred.

6
- The patient (or authorized person) should sign and date the form.

OTHER TIPS FOR FILING A CLAIM

Ensure all statements are itemized and include a charge and a description of each service rendered. If the statement reads "labs" or "x-rays", the description of the procedure should be included, and can be obtained by contacting the provider.

- Statements that read "Balance Due" cannot be processed and will be returned.
- Ensure the provider's name is listed on each statement.
- Any associated hospital charges should be filed separately.
- If claims are filed from a provider that is participating with BCBSGA/BCBSHP, the payment will be sent directly to the provider.
- If you are required to pay up-front or receive balance billing from a participating provider, **please contact customer care immediately.**
- It is always prudent to make copies of the items submitted.

For questions, please call the number on the back of your ID card.

All claim forms should be mailed to:

BCBSGA
PO Box 105370
Atlanta, GA 30348-5370