ATTACH RECEIPTS HERE

Independence Blue Cross

Benefits underwritten or administered by QCC Ins. Co., a subsidiary of Independence Blue Cross – independent licensees of the Blue Cross and Blue Shield Association.

PPO PROGRAM
OUT-OF-NETWORK CLAIM FORM

Please Mail To: **Claims Receipt Center**
P.O. Box 211184
Eagan, MN 55121

(see reverse side for instructions)

I. MEMBER/PATIENT

MEMBER'S NAME *(First, Middle, Last)*		IDENTIFICATION NUMBER	GROUP NUMBER	
PRESENT ADDRESS STREET	D NEW ADDRESS	CITY	STATE	ZIP CODE
PATIENT'S NAME *(First, Middle, Last)*	RELATIONSHIP OF PATIENT TO MEMBER D SELF D SPOUSE D CHILD D HANDICAPPED DEPENDENT D OTHER		SEX D MALE D FEMALE	BIRTH DATE / /

II. OTHER INSURANCE

• Does the PATIENT have additional health insurance benefits? D NO D YES **If yes, complete Part II:**

POLICYHOLDER'S NAME	BIRTH DATE / /	EMPLOYMENT STATUS OF POLICYHOLDER D ACTIVE D DISABLED D RETIRED EFFECTIVE DATE: / /

RELATIONSHIP OF POLICYHOLDER TO MEMBER D SELF D SPOUSE D CHILD D OTHER _____	OTHER INSURANCE CARRIER'S NAME	IDENTIFICATION NO.	EFFECTIVE DATE / /

TYPE(S) OF COVERAGE

D HOSPITALIZATION D MEDICAL-SURGICAL D DENTAL D VISION D DRUG D MAJOR MEDICAL

D OTHER _____

CONTRACT COVERS

D POLICYHOLDER ONLY D POLICYHOLDER AND SPOUSE D POLICYHOLDER AND CHILD(REN) D FAMILY

• Is the PATIENT entitled to benefits under MEDICARE HOSPITALIZATION Insurance (Part A)?

D NO D YES EFFECTIVE DATE: / / MEDICARE ID NUMBER _____

• Does the PATIENT receive benefits under MEDICARE MEDICAL Insurance (Part B)?

D NO D YES EFFECTIVE DATE: / / MEDICARE ID NUMBER _____

If you answered "YES" to either of the above, give employment status of the member listed in Part "I":

D ACTIVE D RETIRED D DISABLED

III. PATIENT'S CONDITION

• DESCRIBE CONDITIONS FOR WHICH YOU ARE REQUESTING BENEFITS AT THIS TIME:

	TYPE OF INJURY/ILLNESS	NAME OF DOCTOR TREATING INJURY/ILLNESS	DATE OF FIRST SYMPTOMS
A.			
B.			

(Attach additional information, if necessary)

• WERE SERVICES RELATED TO HOSPITALIZATION? D NO D YES If yes,

Give date of admission / / Give date of discharge / /

Hospital Name _____ Admitting Physician _____

• WERE EXPENSES DUE TO AN ACCIDENT? D NO D YES If yes, give type/place of accident:

Give date of accident / / D Auto D Work D Other (specify) _____

IV. AUTHORIZATION

I certify that the information provided on this claim form is correct and complete, and that I am claiming benefits only for charges actually incurred by the patient named. I authorize any hospital, physician or other provider who participated in the care and treatment of the patient to release to Independence Blue Cross all medical or other information requested for the processing of this claim. I hereby agree to reimburse Independence Blue Cross in full should this claim be incorrectly paid. 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 fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

MEMBER'S SIGNATURE DATE (AREA CODE) HOME PHONE (AREA CODE) WORK PHONE