BlueCross BlueShield of Georgia

An Independent Licensee of the Blue Cross and Blue Shield Association.

UNIVERSITY SYSTEM OF GEORGIA HEALTH BENEFITS PLAN

HEALTH BENEFITS CLAIM FORM

PLEASE SEE INSTRUCTIONS FOR FILING ON THE REVERSE SIDE.
COMPLETE ALL QUESTIONS TO THE BEST OF YOUR ABILITY.

MAIL TO

Blue Cross and Blue Shield of Georgia
P. O. Box 7728
Columbus, Georgia
31908-7728

I

PATIENT'S IDENTIFICATION NUMBER	GROUP NUMBER	NUMBER OF ATTACHMENTS
	BOR	

II PATIENT INFORMATION — Person who received services

Name (last, first, MI)	Sex	Relationship to Employee	Date of Birth
	☐ Male ☐ Female	☐ Self ☐ Spouse ☐ Child ☐ Other	Mo. Day Yr.

Is Patient Enrolled as a Fulltime Student?	If "YES", Enter Name of School/College	Location of School/College	Anticipated Date of Graduation
☐ YES ☐ NO			

III EMPLOYEE INFORMATION

Name	Address
Daytime Telephone Number	
Home Telephone Number	☐ Check here if this is a new address

IV 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 any of the above questions, please complete the following:

Policyholder's Name	Date of Birth	Policy Number

Insurance Company's Name	Please indicate type coverage
	☐ Health ☐ Dental ☐ Vision ☐ Drug

Insurance Company's Address City State Zip Code

Employer's Name	Group Number	Medicare Number	Medicare
			☐ Part A ☐ Part B

V MEDICAL INFORMATION

Is This Condition An Illness ☐ Injury ☐ Or Wellness Exam ☐ ? Date of Injury Required Mo. Day Yr.

Describe the illness or injury which required treatment

How did the injury occur?

VI

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize the release of any medical information necessary to process this claim and also certify that the above information is correct.)

SIGNED DATE

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

NOTE – Please indicate physician providing service on each physician bill

USG001 Rev. 3/94

INSTRUCTIONS FOR COMPLETION OF THE HEALTH BENEFITS CLAIM FORM

We at Blue Cross and Blue Shield of Georgia, Inc. value your membership. The following tips are offered to ensure accurate and timely processing of your claim. If for any reason you should have questions about this form, your claims or benefits, please call our Customer Service department. The telephone number is listed at the bottom of this page.

I. Your contract number and group number are shown on your Membership card. Please copy the numbers accurately. **Please indicate the number of items you are attaching in the block provided**.

II. The patient is the person who received the health care services or supplies. Please be sure the patient's name is included on every statement you file, along with the month, day and year of each service provided. FILE SEPARATE CLAIM FORMS FOR EACH PATIENT.

Indicate in the additional blocks provided, the patient's sex and relationship to the Employee and the patient's date of birth.

III. Please furnish the Employee's name, current address and zip code. Please indicate if the address given is a change from the previous address on record.

IV. If the patient is covered by another group health insurance program or MEDICARE, check "YES" and furnish the name if the Policyholder, the policy number, the insurance company's name and address, the policyholder's employer and the insurance group. If you are covered by Medicare, please enter your Medicare number and state whether or not you have both Part A and Part B Medicare. **If you do not have other coverage, please check "NO".**

If you are covered by another health insurance company or Medicare, you must furnish your Explanation of Benefits or Explanation of Medicare Benefits for the services you are filing on this claim. If you furnish this at the time you file your claim, this will eliminate a delay in the processing of your claim.

V. Please DESCRIBE THE ILLNESS OR INJURY for which treatment was necessary. In the case of multiple illnesses please indicate the illness of EACH itemization you are attaching. If the treatment was for an injury, you must provide the date of the injury and how the injury occurred. If this information is not included, your claim could be delayed in an effort to obtain the information.

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

OTHER TIPS FOR FILING A CLAIM

1. Make sure all statements are itemized and include a charge and a description of each service rendered. If the statement reads "lab", we must have the description of the procedure; if an x-ray, we must have the description of the x-ray. You should contact your physician's office for this information. STATEMENTS STATING "BALANCE DUE" ARE NOT ACCEPTABLE; you must obtain an itemized statement which is signed by your physician. The PHYSICIAN'S NAME must be on all statements. If multiple physicians are listed, indicate which physician performed the services.

2. Hospital charges must be filed separately.

3. If you are filing charges from an in-network physician, the payment will be sent directly to the physician since the agreement requires the physician to file claims for you. The participating physician has also agreed to accept payment based on the usual, customary and reasonable (UCR) fee allowed before benefit determination is made. You should not be balance billed for charges exceeding the UCR for services rendered when the physician is participating.

4. Please make duplicate copies of all claims for your records.

IF YOU NEED INFORMATION ABOUT COMPLETING THIS FORM OR CLAIMS ASSISTANCE IN GENERAL. PLEASE FEEL FREE TO CALL THE UNIVERSITY SYSTEM OF GEORGIA DIDICATED CUSTOMER SERVICE DEPATMENT AT:

1-800-424-8950