



BELL ATLANTIC MEDICAL PLAN CLAIM FORM

FOR ACTIVE AND RETIRED EMPLOYEES AND THEIR ELIGIBLE DEPENDENTS

IMPORTANT! PLEASE READ THE FOLLOWING BEFORE COMPLETING SIDE ONE

SECTION I - EMPLOYEE/PATIENT INFORMATION

- **FILL OUT THIS SECTION COMPLETELY; ALL THE REQUESTED INFORMATION IS ESSENTIAL FOR FAST AND ACCURATE PROCESSING OF YOUR CLAIM(S).**
- **IN ORDER TO HAVE A CLAIM FOR MEDICAL EXPENSES CONSIDERED FOR PAYMENT, THE CLAIM MUST BE FILED WITHIN 90 DAYS AFTER THE END OF THE CALENDAR YEAR IN WHICH THE EXPENSES WERE INCURRED.**
- **WHEN FILING A CLAIM, MAKE SURE YOU HAVE:**
 1. COMPLETED all information on SIDE ONE, SECTION I of this form.
 2. ATTACHED itemized bills which include:
 - Patient's name
 - Date(s) of service
 - Type(s) of service rendered
 - Individual charges for each date of service
 - Diagnosis
 - Provider tax identification number

Additionally, **original** drug receipts must be submitted and include:

 - Prescription number(s)
 - Name of prescribing physician
 - Name of Pharmacy
 - Name of drug(s) and dosage
- 3. TRANSLATED bills for services outside of the United States into English whenever possible.
- 4. SUBMITTED a separate Medical Plan Claim Form with bills attached for each patient.
- 5. SUBMITTED a separate Medical Plan Claim Form for services incurred within each calendar year for each patient.
- **ARE YOU COVERED BY MEDICARE?**
If yes, make sure you have attached an Explanation of Medicare Benefits (EOMB) for services covered by Medicare; or, attached itemized bills for services not covered by Medicare.
- **ARE YOU COVERED BY OTHER HEALTH INSURANCE?**
If other health insurance is primary, make sure you have attached an Explanation of Benefits (EOB) and itemized bills.
- **IMPORTANT NOTE REGARDING HOSPITAL CLAIMS:**
In most situations the hospital will bill Blue Cross and Blue Shield directly. In these situations you are not required to complete this claim form. If you receive a hospital bill for covered services, you should complete SECTION I of this form, attach the itemized hospital bill and submit both to the address indicated on SIDE ONE of this claim form. If you have paid for the hospital services, please attach proof of payment.

SECTION II - PHYSICIAN OR SUPPLIER INFORMATION

- **FILL OUT THIS SECTION COMPLETELY OR ATTACH ITEMIZED BILLS FOR SERVICES RENDERED; ALL THE REQUESTED INFORMATION IS ESSENTIAL FOR FAST AND ACCURATE PROCESSING.**
 - **REFER TO THE FOLLOWING WHEN COMPLETING BOX 22A ON SIDE ONE, SECTION II OF THIS FORM.**
- BOX 22A - PLACE OF SERVICE CODES**
- 1- Inpatient Hospital
 - 2- Outpatient Hospital, Ambulatory Surgery Center
 - 3- Doctor's Office
 - 4- Patient's Home