



Horizon Blue Cross Blue Shield of New Jersey

# Horizon Traditional and PPO Health Insurance Claim Form

THIS FORM CAN BE DOWNLOADED FROM OUR WEB SITE AT [www.HorizonBlue.com](http://www.HorizonBlue.com)

Please Print This Form In Color (If Available).

## INSURED'S INFORMATION

1. LAST NAME  FIRST NAME  MI

2. DATE OF BIRTH  3. SEX   4. IDENTIFICATION NUMBER

MM DD YYYY M F Prefix (if any) Number Portion

6. ADDRESS  CITY  STATE  ZIP CODE

(No., Street)

7. TELEPHONE NUMBER  8. EMPLOYER'S NAME

(Include Area Code)

9. INSURANCE PLAN NAME OR PROGRAM NAME  10. IS THERE ANOTHER INSURANCE PLAN?  No  Yes

**IF YES, COMPLETE ITEMS 20 - 26**

## PATIENT'S INFORMATION (If Patient is the same as the Insured, please skip to #16)

11. LAST NAME  FIRST NAME  MI

12. DATE OF BIRTH  13. SEX   14. TELEPHONE NUMBER

MM DD YYYY M F (Include Area Code)

15. ADDRESS  CITY  STATE  ZIP CODE

(No., Street)

16. RELATIONSHIP TO INSURED  Self  Spouse/DP  Child  Other  17. PATIENT'S STATUS  Single  Married  Other  EMPLOYED  FULL-TIME STUDENT  PART-TIME STUDENT

18. IS PATIENT'S CONDITION RELATED TO:  
 a. EMPLOYMENT? (Current or Previous)  No  Yes  
 b. AUTO ACCIDENT?  No  Yes  
 PLACE (State)  c. OTHER ACCIDENT  No  Yes

19. DATE OF CURRENT ILLNESS

MM DD YYYY **ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)**

## OTHER INSURANCE INFORMATION

20. LAST NAME OF POLICY HOLDER  FIRST NAME  MI

21. DATE OF BIRTH  22. SEX   23. IDENTIFICATION NUMBER

MM DD YYYY M F

24. TELEPHONE NUMBER  25. EMPLOYER'S NAME OR SCHOOL NAME

(Include Area Code)

26. INSURANCE PLAN NAME OR PROGRAM NAME

## AUTHORIZATION

27. 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 Horizon Blue Cross Blue Shield of New Jersey all medical or other information requested for the processing of this claim form. I hereby agree to reimburse Horizon Blue Cross Blue Shield of New Jersey, in full should this claim be incorrectly paid.

SIGNATURE OF PATIENT (unless a minor) \_\_\_\_\_ DATE \_\_\_\_\_

## 28. AUTHORIZATION FOR ASSIGNMENT OF BENEFITS

Horizon Blue Cross Blue Shield of New Jersey, at its discretion, may accept an Assignment of Benefits. 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 \_\_\_\_\_ TAX NUMBER (Required) \_\_\_\_\_ NPI NUMBER \_\_\_\_\_

SIGNATURE OF INSURED \_\_\_\_\_ DATE \_\_\_\_\_

**SEE BACK OF THIS FORM FOR IMPORTANT INFORMATION**

## PLEASE READ THIS IMPORTANT INFORMATION

WHEN YOU ARE SUBMITTING EXPENSES FOR MORE THAN ONE FAMILY MEMBER, PLEASE USE A SEPARATE CLAIM FORM FOR EACH PERSON. ITEMIZED BILLS FOR COVERED SERVICES OR SUPPLIES MUST BE ATTACHED TO THIS FORM AND INCLUDE THE FOLLOWING:

Check that each itemized bill is legible and contains ALL of the following information:

- NAME & ADDRESS of person or institution rendering the service or supplying the item
- Health Care Professional Federal Tax Identification Number (Required)
- Health Care Professional NPI Number
- PATIENT'S FULL NAME
- TYPE of service rendered/produced or item supplied
- DATE each service rendered or item supplied
- AMOUNT charged for each service rendered or item supplied
- DIAGNOSIS of ailment

**BILLS MISSING ANY OF THIS INFORMATION 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.

## COORDINATION OF BENEFITS?

If you or your covered dependent(s) are covered by another health insurance program, please provide 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, 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 PATIENT is eligible for Medicare Benefits, be sure you include the Explanation of Medicare Benefits (EOMB) that was sent to patient explaining the charges paid or not paid by Medicare.

To process a claim for your Horizon Blue Cross Blue Shield of New Jersey, supplementary insurance, we need a copy of the Explanation of Medicare Benefits (EOMB). This EOMB should have been sent to you when Medicare processed your claim. If your EOMB has more than one page, send us copies of all pages. Please write your Horizon Blue Cross Blue Shield of New Jersey identification number clearly on the first page.

**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 use a separate claim form for each person. It is suggested that you make copies for your own use before you submit the original bills.

Prescription Drugs? Bills must show the patient's name and date of service, prescription number and amount paid, name, strength & quantity 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.

**Please mail completed claim form to: Horizon Blue Cross Blue Shield of New Jersey  
P.O. Box 1609  
Newark, New Jersey 07101-1609**

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### 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