



P.O. Box 1219  
Newark, NJ 07101-1219

Horizon Blue Cross Blue Shield of New Jersey

CARRIER  
PATIENT AND INSURED INFORMATION  
PHYSICIAN OR SUPPLIER INFORMATION

(PLEASE TYPE OR PRINT)

# National Accounts Health Insurance Claim Form

1. MEDICARE <input type="checkbox"/> (Medicare #)            MEDICAID <input type="checkbox"/> (Medicaid #)            CHAMPUS <input type="checkbox"/> (Sponsor's SSN)            CHAMPVA <input type="checkbox"/> (VA File #)            GROUP HEALTH PLAN <input type="checkbox"/> (SSN or ID)            FECA BLK LUNG <input type="checkbox"/> (SSN)            OTHER <input type="checkbox"/> (ID)		1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1) PREFIX (if any) _____ NUMBER PORTION _____																																																																																																				
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		3. PATIENT'S BIRTH DATE MM   DD   YY    SEX    M <input type="checkbox"/> F <input type="checkbox"/>																																																																																																				
5. PATIENT'S ADDRESS (No., Street)		6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>																																																																																																				
CITY _____ STATE _____		7. INSURED'S ADDRESS (No., Street)																																																																																																				
ZIP CODE _____ TELEPHONE (Include Area Code) ( ) _____		8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/> Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>																																																																																																				
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO:																																																																																																				
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input type="checkbox"/> NO																																																																																																				
b. OTHER INSURED'S DATE OF BIRTH MM   DD   YY    SEX    M <input type="checkbox"/> F <input type="checkbox"/>		b. AUTO ACCIDENT? PLACE (State) _____ <input type="checkbox"/> YES <input type="checkbox"/> NO																																																																																																				
c. EMPLOYER'S NAME OR SCHOOL NAME		c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO																																																																																																				
d. INSURANCE PLAN NAME OR PROGRAM NAME		10d. RESERVED FOR LOCAL USE																																																																																																				
11. INSURED'S POLICY GROUP OR FECA NUMBER  a. INSURED'S DATE OF BIRTH MM   DD   YY    SEX    M <input type="checkbox"/> F <input type="checkbox"/> b. EMPLOYER'S NAME OR SCHOOL NAME c. INSURANCE PLAN NAME OR PROGRAM NAME		11. INSURED'S POLICY GROUP OR FECA NUMBER  a. INSURED'S DATE OF BIRTH MM   DD   YY    SEX    M <input type="checkbox"/> F <input type="checkbox"/> b. EMPLOYER'S NAME OR SCHOOL NAME c. INSURANCE PLAN NAME OR PROGRAM NAME																																																																																																				
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.  SIGNED _____ DATE _____		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.  SIGNED _____																																																																																																				
14. DATE OF CURRENT: MM   DD   YY    ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)		15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM   DD   YY																																																																																																				
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE		17a. I.D. NUMBER OF REFERRING PHYSICIAN																																																																																																				
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO																																																																																																				
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.																																																																																																				
23. PRIOR AUTHORIZATION NUMBER		24. TABLE																																																																																																				
1. _____    3. _____ 2. _____    4. _____		<table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th>A</th> <th>B</th> <th>C</th> <th>D</th> <th>E</th> <th>F</th> <th>G</th> <th>H</th> <th>I</th> <th>J</th> <th>K</th> </tr> <tr> <th>DATE(S) OF SERVICE From MM   DD   YY To MM   DD   YY</th> <th>Place of Service</th> <th>Type of Service</th> <th>PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS   MODIFIER</th> <th>DIAGNOSIS CODE</th> <th>\$ CHARGES</th> <th>DAYS OR UNITS</th> <th>EPSDT Family Plan</th> <th>EMG</th> <th>COB</th> <th>RESERVED FOR LOCAL USE</th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> </tbody> </table>		A	B	C	D	E	F	G	H	I	J	K	DATE(S) OF SERVICE From MM   DD   YY To MM   DD   YY	Place of Service	Type of Service	PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS   MODIFIER	DIAGNOSIS CODE	\$ CHARGES	DAYS OR UNITS	EPSDT Family Plan	EMG	COB	RESERVED FOR LOCAL USE																																																																													
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25. FEDERAL TAX I.D. NUMBER    SSN EIN <input type="checkbox"/> <input type="checkbox"/>		26. PATIENT'S ACCOUNT NO.																																																																																																				
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)		27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO																																																																																																				
SIGNED _____ DATE _____		28. TOTAL CHARGE \$ _____																																																																																																				
32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)		29. AMOUNT PAID \$ _____																																																																																																				
33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #		30. BALANCE DUE \$ _____																																																																																																				
PIN# _____		GRP# _____																																																																																																				

