Claim form | H9699 HMO

A separate claim form must be submitted for each member when sending bills to Arkansas Blue Medicare

Please refer to the instructions on back of this form when filing your claims.

Arkansas Blue Medicare identification number (as indicated on your identification card including the three-digit prefix)	**Group number**

Member information

Last name	**First name**	**M.I.**	**Date of birth** (mm/dd/yyyy)	**Sex** Male Female

Physical Address	**City**	**State**	**ZIP**
Mailing Address	**City**	**State**	**ZIP**

Date of service (mm/dd/yyyy)

Other insurance

This part must be completed in full before we can determine responsibilities for your claim.

Other medical insurance? No Yes	**Name of other health insurance**

Policy's/certificate holder's information

Last name	**First name**	**M.I.**	**Policy holder's employer**

I certify the above information is true, the enclosed material is correct and unaltered, and the expenses were incurred by the member listed above. False receipts or altering of this information could result in civil or criminal prosecution. I authorize the release of any information as described below.

Policy/Certificate Holder's Signature	**Date signed**

If you have any questions, please contact customer service:

Arkansas Blue Medicare HMO: 844-201-4934

Arkansas Blue MEDICARE

An Independent Licensee of the Blue Cross and Blue Shield Association

P.O. Box 3648
Little Rock, Arkansas 72203-3648

Form No. 07-63 R4/94 00480.05.01-0623

General information

You should submit your bills in a timely manner. To speed the processing of your claim, all bills must be itemized and attached to the claim form. ALL items on the claim form must be completed to insure proper payment.

Note: cancelled checks, payment receipts, or balance forward bills are not acceptable

How to file a claim

Preparation of bills

Separate bills into the following groups:

1. Physician's Bills
2. Pharmacy Bills
3. Physical Therapy & Speech Therapy Bills
4. Ambulance Bills
5. Hospital Bills
6. Durable Medical Equipment
7. Other Bills

Things to remember

1. Enter FULL name of member; member's date of birth (month, day and year), and date of service (month, day and year).
2. You must enter the correct and complete identification and group numbers for claim to be processed.
3. You must enter the correct and complete address for mailing of payment.

Check the bills for the following information:

1. Physician's Bills - (Must be submitted on physician's office bill or an Arkansas Blue Medicare claim form.)
   a. Full name of member
   b. Date(s) of service
   c. Full description of the type of procedures, medical services or supplies furnished for each date
   d. Amount charged for each service
   e. Diagnosis
2. Pharmacy Bills - (Must be submitted on official pharmacy invoice or stationery. **NOTE: Claims can only be submitted for Part B drugs only.)**
   a. Full name of member
   b. Date(s) of purchase
   c. Prescription number
   d. Amount charged for each prescription
   e. Name of drug

Check the bills for the following information:

3. Physical Therapy and Speech Therapy Bills (Must be on therapist's stationery)

a. Full name of member
b. Date(s) of service
c. Charge for each service
d. Name of licensed therapist

4. Ambulance Bills (Bills must be on ambulance firm's letterhead)

a. Full name of member
b. Mileage of trip
c. Charges per mile
d. Points of departure and mileage
e. Description of other services (i.e., oxygen, equipment, etc.)

5. Hospital Bills

a. Itemized statement from hospital, which must include diagnosis

6. Durable Medical Equipment Bills - (Bill must include an invoice from the supplying firm) **NOTE: Prior Authorization is required when renting or purchasing Durable Medical Equipment**

a. Full name of member
b. Date(s) of services
c. Description of items
d. Charge for each item
e. Must have supporting statement from physician.

7. Other Bills - (Must include an invoice from the person or organization who provided the services)

a. Name of person or organization who provided the services
b. Full name of member
c. Date the service was provided
d. Description of services
e. Charge for each service

Note: Do not use this form to file charges which are being filed for you by the hospital and/or physician. Please check with the hospital and/or physician (or other providers of care) before filing the claim yourself.