

CATASTROPHIC HEALTH
EXPENSE PROGRAM
HOW TO FILE A CLAIM

1. All items must be completed on the Catastrophic Health Expense Program Claim form.

2. **If you have Medicare:**

- (a) Assemble all of your Medicare Explanation of Benefits along with all of your Supplemental Explanation of Benefits.
- (b) For all of your hospital, skilled nursing, extended care facility, and homecare/hospice charges, you must obtain a Medicare Remittance Notice from the hospital where your services were rendered. You will have to call the hospital's billing department to request the information. The hospital can fax the information to (410) 998-6696, Attention: Catastrophic Unit. A Medicare Remittance Notice is the explanation of benefits **the hospital receives** from Medicare which shows Medicare's actual payment including the adjustments. **We cannot process your hospital claim without the Remittance Notice.**

If you do not have Medicare:

- (a) Assemble all of your Primary and Secondary Insurance Explanation of Benefits.
- (b) Assemble all of your bills and ensure that they are fully itemized and on the letterhead stationary of the provider of service. If you do not have an itemized bill, you can request a "HCFA 1500" form, which is the standard billing form all providers use to bill insurance companies. If you do have an itemized bill, make sure it has all of the following information:
 - 1. The patient's name
 - 2. Procedure code
 - 3. The dates of service
 - 4. The charge per service
 - 5. Diagnosis
 - 6. The name of the drug (pharmacy only)
 - 7. Provider name

Cancelled checks, cash register slips and personal itemizations are not acceptable.

Note: Your bills cannot be returned to you. Please obtain photocopies for your records before submitting your claim.

3. With your completed claim form, send your itemized bills, Explanation of Benefits, Medicare Remittance Notices, or other documentation of charges to us:

CareFirst BlueCross BlueShield
P.O. Box 14115
Lexington, KY 40512-4115

4. If bills are submitted for more than one family member at a time, a separate claim form and separate bills must be submitted for each family member.

5. When to submit your claim: Claims should be submitted when your covered expenses EXCEED your Catastrophic Health Expense Program deductible of \$50,000, and by December 31 following the calendar year for which the covered service was rendered.

In some instances, it may be necessary for the Special Benefits Division, after an initial review of the claim, to request additional information before a final benefit determination can be made. **It is the Policyholder's responsibility to provide additional information requested.**

6. If you have any questions, please call us at the following telephone number:
(410) 581-3404 or toll-free 1-800-338-2228.

DOCTOR BILLS

Should include the following information

1. FULL NAME OF PATIENT (Separate bill should be submitted for each member of family for whom Catastrophic Health Expense Program expense benefits are being claimed)	George S. Smith, M.D. 100 Market Street Hometown		
	FOR PROFESSIONAL SERVICES TO: Mary G. Jones		
2. DATE OF EACH TREATMENT	Date of treatment	Charge	Name of condition and service
3. TREATMENT SHOWN SEPARATELY	8/31/08	\$5.00	Anemia-office visit
	9/11/08	\$5.00	Anemia-office visit
	9/22/08	\$5.00	Anemia-office visit
	10/05/08	\$10.00	Suture of laceration (left hand)
4. ACTUAL NAME OF AILMENT AND SERVICE	11/03/08	\$5.00	Virus-office visit
5. ALLOWANCE(S)	CareFirst BlueCross BlueShield paid \$10.00 for October 5, 2008, suture of laceration.		

DRUGGIST BILLS

Should include the following Information

1. FULL NAME OF PATIENT (Separate bill should be submitted for each member of family for when Catastrophic Health Expense Program benefits are being claimed)	PRICE PHARMACY 200 Market Street Hometown		
	PATIENT'S FULL NAME Mary G. Jones		
2. DATE OF PURCHASE	Date	Prescription Number	Charge
3. PRESCRIPTION NUMBER AND DRUG NAME	8/31/08	#12469 Demerol Dr. G. S. Smith	\$2.75
		#12470 Demerol Dr. G.S.Smith	\$1.40
4. SEPARATE CHARGE FOR EACH PRESCRIPTION	10/05/08	#11559 Demerol Dr. T.M. Black	\$3.95
5. PRESCRIBING DOCTOR	11/15/08	#11560 Demerol Dr. R. B. Brown	\$14.95
		Total	\$22.35