

**STATE OF MARYLAND EMPLOYEES HEALTH / VISION PLAN
EMPLOYEE CLAIM FORM**

1.

Subscriber's Legal Name (Last, First, Middle Initial)		Patient's Legal Name (Last, First, Middle Initial)			
Membership Number		Patient's Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		Patient's Relationship to Subscriber 1 2 3 4 <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	
Subscriber's Address (Street) <input type="checkbox"/> Check box if NEW address		Patient's Date of Birth		Month	Date
City State Zip Code		NOTE: See reverse side for claim filing instructions including Routine Vision Care Services			
Telephone Number					
Group Number					

IMPORTANT: ALL QUESTIONS MUST BE ANSWERED

2.

List those illnesses for which you are submitting bills and date of first symptom.

_____	Date	_____	Date
_____	Date	_____	Date

3.

Was the treatment a result of an injury? Yes No Was the treatment a result of an automobile accident? Yes No

Description of Accident _____

Date of Accident _____ Where Accident Occurred _____

4.

Was illness(es) or injury(ies) in any way work related? Yes No

5.

Does patient have Medicare? _____ Effective Date of Coverage _____

a. Medicare Part A (Hospital Insurance)? Yes No Month Day Year HEALTH INSURANCE CLAIM NUMBER

b. Medicare Part B (Physician's Coverage)? Yes No Month Day Year _____

6.

In addition to coverage under this program, is patient covered under any other insurance providing health care benefits or services?
 Yes No If "Yes", please complete:

a. Name of Policy Holder _____ Relationship to Patient _____

b. Name of Insuring Co. _____

c. Policy or Certificate No. _____ d. Effective Date of Coverage _____ / _____ / _____
Month Day Year

e. Check type of coverage: Hospital Surgical-Medical Major Medical Other (specify) _____

f. Check One: I have Family Husband and Wife Individual Parent and Child coverage with this carrier.

g. Name and Address of Policy Holder's Employer _____

7.

I certify the above is complete and correct and that I am claiming benefits only for charges incurred by the patient named above.
Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
Authorization is hereby given to any hospital, physician, or other provider which participated in any way in my care and treatment to release to CareFirst BlueCross BlueShield any medical information which they in their judgement deem necessary to the adjudication of this claim.

X _____ SIGNATURE OF SUBSCRIBER _____ DATE _____
Administrative Use Only
Do not write in this space
Provider# _____ Initials _____

HAVE YOU ATTACHED YOUR ITEMIZED BILLS?



**Mail Administrator
P.O. Box 14115
Lexington, KY 40512-14115**

STATE OF MARYLAND EMPLOYEES HEALTH / VISION PLAN EMPLOYEE CLAIM FORM

This form is to be used only by members of the State Employees Health Plan to file **PPO, POS, EPO** and **Routine Vision Care** claims. While participating providers will bill CareFirst BlueCross BlueShield for services rendered, you may have claims to file yourself if you see non-participating providers.

- A copy of the bill on the provider’s letterhead stationary

IN ORDER FOR YOUR CLAIMS TO BE PROCESSED, THE FOLLOWING INFORMATION MUST BE SUBMITTED

The bill must include:

- Provider’s full name, degree, address, phone # and CareFirst BlueCross BlueShield provider number if available.
- Patient’s full name
- Descriptions of each service or supply (**vision claims see outline below**)
- Date of which each service was provided
- The provider’s diagnosis, or patient’s chief complaint
- The amount charged by the provider for each service provided
- Bills in foreign language should be translated to English, foreign currency should be converted to American dollars
- Original bills should be submitted
- Keep a copy of your bills and claim for your records
- Provider’s signature is required

- A completed claim form. Please be sure to accurately complete all sections of the claim form. Always use one claim form per patient.
- When another insurance carrier (including Medicare) is paying your claim first, please submit a copy of their payment statement with your claim. These statements are sometimes called “Explanation of Benefits,” “Summary of Benefits,” “Explanation of Medicare Benefits.”

BILLS FOR THE FOLLOWING SERVICES SHOULD INCLUDE THIS ADDITIONAL INFORMATION

- Office Visits: Type of visit (brief, intermediate, extended, etc.)
- Routine Vision: Date of visit, procedure codes for exam, lenses and frames. (See Chart Below)
- Private Duty Nursing:..... Dates and shifts worked, amount charged for each shift, prescribing Doctor’s name and degree, and registration # of nurse.
- Durable Medical Equipment:..... Include the full purchase price of any rented equipment. A letter of medical necessity from your (wheelchair, respirator, oxygen, etc.) physician must be submitted with the claim.
- X-rays:..... Type of x-ray (chest, legs, etc.)
- Blood Charges: Include the number of pints received, charges for each, and the number of pints replaced by donors. Indicate whether bill is for whole blood, plasma or derivatives.
- General Anesthesia:..... The length of time (in minutes) the patient was under general anesthesia must appear on the bill.
- Accidental Injury Claims:..... Must indicate the date on which the accident occurred.

Members of the Preferred Provider Option (PPO), Exclusive Provider Organization (EPO) and Point of Service (POS) – Note: Must have pre-authorization on file after the first 10 visits for outpatient physical therapy, occupational therapy and speech therapy. See your benefit booklet, section: Managed Care Authorization Program for more information.

ELIGIBLE VISION SERVICES

Description of Service	Procedure Code	Service Date	Charge
<input type="checkbox"/> EXAM	92002-92004 92012-92014		
<input type="checkbox"/> FRAME-DISPLAY <input type="checkbox"/> YES <input type="checkbox"/> NO	V2020		
<input type="checkbox"/> SINGLE VISION	V2100-V2114		
<input type="checkbox"/> BIFOCAL, SINGLE	V2200-V2214		
<input type="checkbox"/> BIFOCAL, DOUBLE	V2799		
<input type="checkbox"/> TRIFOCAL	V2300-V2314		
<input type="checkbox"/> APHAKIC (LENTICULAR)	V2116-V2217		
<input type="checkbox"/> CONTACT LENSES (NOT MEDICALLY REQUIRED)	V2500-V2522		
<input type="checkbox"/> CONTACT LENSES (MEDICALLY REQUIRED)	V2799		

DATE OF CATARACT SURGERY: _____. VISUAL ACUITY BEFORE LENSES: _____. VISUAL ACUITY AFTER LENSES: _____.
 WOULD GLASSES CORRECT VISUAL ACUITY TO AT LEAST 20/70 IN THE BETTER EYE? YES NO

NOTE: PROCEDURE CODE MAY VARY ACCORDING TO SERVICE PROVIDED.