13 Sample Forms

- Health Insurance Claim Form HCFA 1500
- General Fax Authorization Request
- Obstetrical Fax Authorization Request
- Wellness Checklists

[redacted]

Empire BlueCross BlueShield
PO BOX 1407, CHURCH STREET STATION
NEW YORK, NY 10008-1407
FOR CUSTOMER SERVICE: 1-800-453-0113

APPROVED OMB-0938-0008

NOTE: Important filing instructions on reverse page.

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE ☐ (Medicare #)	MEDICAID ☐ (Medicaid #)	CHAMPUS ☐ (Sponsor's SSN)	CHAMPVA ☐ (VA File #)	GROUP HEALTH PLAN ☒ (SSN or ID)	FECA BLK LUNG ☐ (SSN)	OTHER ☐ (ID)	1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)			3. PATIENT'S BIRTH DATE MM DD YY	SEX M ☐ F ☐			4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No. and Street)			6. PATIENT RELATIONSHIP TO INSURED	Self ☐ Spouse ☐ Child ☐ Other ☐			7. INSURED'S ADDRESS (No. and Street)
CITY	STATE		8. PATIENT STATUS	Single ☐ Married ☐ Other ☐			CITY / STATE
ZIP CODE	TELEPHONE (Include Area Code)			Employed ☐ Full-Time Student ☐ Part-Time Student ☐			ZIP CODE / TELEPHONE (Include Area Code)
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)			10. IS PATIENT'S CONDITION RELATED TO:				11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER			a. EMPLOYMENT? (Current or Previous)	YES ☐ NO ☐			a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐			b. AUTO ACCIDENT?	YES ☐ NO ☐ PLACE (State)			b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME			c. OTHER ACCIDENT?	YES ☐ NO ☐			c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME			d. RESERVED FOR LOCAL USE				d. IS THERE ANOTHER NAME OR BENEFIT PLAN? YES ☐ NO ☐ If YES, return to and complete item 9a–d.

READ BACK OF FORM BEFORE COMPLETING THIS SECTION.

12. I AUTHORIZE THE RELEASE OF INFORMATION AS DESCRIBED ON THE REVERSE SIDE OF THIS CLAIM FORM.

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 **NOT APPLICABLE**

PHYSICIAN SUPPLIER INFORMATION

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	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	17a. I.D. NUMBER OF REFERRING PHYSICIAN	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE) 1. ____ . __ 3. ____ . __ 2. ____ . __ 4. ____ . __		22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE FROM MM DD YY TO MM DD YY	B PLACE OF SERVICE	C TYPE OF SERVICE	D PROCEDURES, SERVICES OR SUPPLIES (EXPLAIN UNUSUAL CIRCUMSTANCES) CPT/HCPCS MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT FAMILY PLAN	I EMG	J COB	K RESERVED FOR LOCAL USE
1										
2										
3										
4										
5										
6										

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? YES ☐ NO ☐	28. TOTAL CHARGE $	29. AMOUNT PAID $	30. BALANCE DUE $
31. SIGNATURE OF PHYSICIAN OR SUPPLIER, INCLUDING DEGREES OR CREDENTIALS I CERTIFY THAT THE CARE, SERVICES AND SUPPLIES ENTERED ON THIS FORM HAVE BEEN RENDERED TO THE PATIENT, AND THAT I AM ENTITLED TO REIMBURSEMENT OF THE CHARGES INDICATED. SIGNED DATE	32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (if other than home or office)		33. PHYSICIANS, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE AND PHONE NUMBER PIN# GRP#		

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90)
FORM OWCP-1500

FILING INSTRUCTIONS

MEMBERS: You are required to complete this claim form if you receive services from a nonparticipating physician (any physician that is "out-of-network").

1. Complete the patient and insured information sections **(Boxes 1–12)**.
   - Please make sure the three-letter alpha prefix, along with the insured's member identification number, appears in **Box 1a. Do not complete Box 13**.
2. Attach the original itemized bill from the physician to the claim form and mail it to the address listed on the front of the form.

   OR

   Have the physician complete the physician supplier information sections **(Boxes 14–33).** Then mail it to the address listed on the front of the form.

NOTE: If you receive services from a participating physician (an "in-network" physician), you are not required to complete any claim forms. All participating network physicians submit claims directly to their local Blue Cross and/or Blue Shield plan.

If you have any questions about completing this claim form, please call the Customer Service telephone number listed on the front of the form or the number on the back of your member identification card.

PROVIDERS: If you have rendered services to a member, please complete the physician supplier information sections **(Boxes 14–33)**. Then mail it to the address listed on the front of the form.

PATIENT'S SIGNATURE

The patient must sign the claim form, authorizing the release of information to Empire or its designee as described below. If the patient is a minor, the signature must be that of the patient's parent or legal guardian.

I authorize any healthcare provider, payor of health claims or government agency to furnish to Empire or its designee all records pertaining to medical history, services rendered, or payments made regarding me or my dependents for review and evaluation of any claim or services.

I authorize Empire or its designee to disclose such information to another payor or self-insurer. If my coverage is under a group contract held by an employer, association, trust fund, union or similar entity, this authorization also permits disclosure to them for purposes of utilization review or financial audit.

This authorization shall become effective immediately, and shall remain in effect until the latest of six years after the termination of coverage, or the last determination or payment by Empire on a claim or service under the coverage. This authorization shall be binding upon me, my dependents, my heirs, executors or administrators.

FRAUD STATEMENT

Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto, may be guilty of a criminal act punishable under law and may be subject to civil penalties.

Empire BlueCross BlueShield

General Fax Authorization Request
Medical Management
Fax 1-800-241-5308

Member/Subscriber Information: ID No.: _____

Last Name: _____ First Name: _____

Patient Information: Last Name: _____ First Name: _____

Relationship to Member/Subscriber: ☐ Self ☐ Spouse ☐ Child DOB: _____ Sex: ☐ M ☐ F

Separate Insurance:
Is this service related to: ☐ A Motor Vehicle Accident? ☐ Worker's Compensation? (check one)

Is there any other insurance? ☐ Yes ☐ No

If yes, name of other insurance carrier: _____

Is the other insurance primary? ☐ Yes ☐ No

Authorization requested for: (check one service per fax form) ☐ Emergency ☐ Scheduled

☐ Inpatient Acute
☐ Ambulatory Surgery
☐ Inpatient Rehabilitation
☐ Skilled Nursing Facility
☐ Hospice

•Admission date:_____
•Requested length of stay (days): _____

☐ Air Ambulance
☐ Radiology Services (☐ MRI ☐ MRA ☐ CT Scan ☐ PET Scan ☐ Nuclear Cardiology)
☐ Outpatient Therapy (☐ PT ☐ OT ☐ ST ☐ Vision)
☐ Cardiac Rehab ☐ Home Care ☐ Home Infusion
☐ Referral to Nonparticipating Provider

• First date of service: _____ **No. visits requested:**_____
• Authorization period requested (days): _____

Primary Diagnosis: _____ ICD9 CODE: _____
Secondary Diagnosis: _____ ICD9 CODE: _____
Procedure: CPT4 Code: _____ CPT4 CODE: _____
Facility/Provider Information: Name: _____
Physician Information:
Name of ordering physician: _____ Provider No.: _____
Phone No.: _____ *(area code)* Fax No.: _____ *(area code)*
Address: _____
Fax request submitted by: Name: _____

FOR EMPIRE USE

Authorization Status:
Approved: ☐ Yes LOS Authorized: _____ OR No. of visits _____ for period of _____days authorized
Authorization No.: _____ *Date authorization completed: _____
Denied: ☐ Yes By: _____ Phone No.: _____ *(area code)*
Pended: For Additional medical information _____ For medical review _____
Comments: _____

*** This authorization is based upon medical necessity, subject to the terms and conditions of the member's contract and is NOT a guarantee of payment.**

Empire BlueCross BlueShield

Obstetrical Fax Authorization Request
Medical Management
Fax 1-800-241-5308

Member/Subscriber Information: ID No.: _____

Last Name: _____ First Name: _____

Patient Information:

Last Name: _____ First Name: _____

Relationship to Member/Subscriber: Self _____ Spouse _____ Child _____ DOB: _____

Separate Insurance:

Is there any other insurance? Yes _____ No _____

If yes, name of other insurance carrier _____

Is the other insurance primary? Yes _____ No _____

- Was there a prenatal visit first trimester? Yes _____ No _____

  Date of first prenatal visit _____

  EDC _____

  Facility for delivery _____

- Type of delivery anticipated: NVD _____ VBAC _____ C-Section _____

  If C-Section, please give reason: _____

- High-Risk: Yes _____ No _____

  If high-risk, please give reason: _____

- Is patient considering sterilization (tubal ligation) post delivery: Yes _____ No _____
- Does the patient have diabetes Yes _____ No _____
- Does an immediate family member have diabetes? Yes _____ No _____

  If yes, what is the family member's relationship to the patient?

Mother	Father	Sister	Brother	Child
Grandmother	Grandfather	Maternal Aunt/Uncle	Paternal Aunt/Uncle	Other

- Is the patient expecting a multiple birth? Yes _____ No _____

Name of obstetrical physician: _____ Provider No.: _____

Phone No.: _____ (area code) Fax No.: _____ (area code)

Address: _____

PLEASE NOTIFY US IF THE LENGTH OF STAY EXTENDS BEYOND WHAT IS AUTHORIZED BELOW.

FOR EMPIRE USE

Authorization Status:

Approved: Yes _____ LOS and/or Number of visits authorized: _____

Authorization No.: _____ *Date authorization completed: _____

Denied: Yes _____ By: _____ Phone No: _____ (area code)

Pended: For each additional medical information _____ For medical review _____

Comments: _____

_____

_____

*** This authorization is based upon medical necessity, subject to the terms and conditions of the member's contract and is NOT a guarantee of payment.**

ENR 0237B 6/04

Empire BlueCross BlueShield

ADULT

Problems, Medications & Wellness Checklist

Patient Name _____ DOB _____

Allergies _____

PCP _____

OB/GYN Provider _____

Other Health Care Providers _____

Chronic Problems	Date of Onset	Resolved

Medications	Start Date	End Date

Health Maintenance	Date	Results	Date	Results	Date	Results
PAP / Pelvic						
Breast Exam						
Mammography						
Stool for OB						
Sigmoidoscopy / BaEnema or Colonoscopy						
Cholestrol / HDL						
Prostate Exam / PSA						
Glucose						
Hgb & Hct						
Hearing						
Vision						
Dental						

Immunizations	Date	Date	Date	Date	Date
Influenza					
Pneumococcus					
Hepatitis					
Tetanus-Diptheria					
Rubella					
Other					

Empire BlueCross BlueShield

PEDIATRIC

Problems, Medications & Wellness Checklist

Patient Name _____ DOB _____

Allergies _____

PCP _____

Other Health Care Providers _____

Chronic Problems	Date of Onset	Resolved

Medications	Start Date	End Date

Health Maintenance	Date	Results	Date	Results	Date	Results
Hgb & Hct						
Lead Level						
Dental						
Hearing						
Vision						
Blood Pressure						
Other:						
Other:						
Other:						