



**State and School Employees'
Health Insurance Plan**

Self-Insured by the State of Mississippi

Motivating Mississippi - Keys to Living Healthy

MEDICAL CLAIM FORM

• • • **IMPORTANT: PLEASE READ THE INSTRUCTIONS ON PAGE 2 OF THIS FORM** • • •

• • **Your Physician does not need to sign this form** • •

Please complete and sign a separate form for each patient.

PATIENT INFORMATION

1. Patient's Name (No nicknames please)		3. Patient's Date of Birth	
_____	_____	____/____/____	
First	MI	Month	Day Year
2. Name as Shown on I.D. Card		4. Identification Number as Shown on I.D. Card	
_____	_____	_____	
First	MI	Last	
7. Current Mailing Address <input type="checkbox"/> Check here if new address.		5. Patient's Sex	6. Patient's Relationship to Employee
_____		<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Self <input type="checkbox"/> Child <input type="checkbox"/> Spouse <input type="checkbox"/> Other
Street _____		City _____ State _____ Zip _____	
Current Telephone Numbers: Home _____		Office _____	
Area Code _____		(optional) Area Code _____	
Payments and Explanation of Benefits will be sent to the most current address listed in our files.			

OTHER HEALTH INSURANCE INFORMATION

8. Is patient covered under any other health insurance plan? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, complete the following: Name of Policyholder _____	
_____	_____
Last	First Middle
Name of Employer (if group coverage) _____	
Name and Address of Insuring Company _____	
Name _____	
Street _____	
Policy # _____	_____
City	State Zip
9. Is patient covered under Medicare Part A (hospital) or Medicare Part B (medical):	
Medicare Part A <input type="checkbox"/> Yes <input type="checkbox"/> No	Effective Date ____/____/____
Month Day Year	
Medicare Part B <input type="checkbox"/> Yes <input type="checkbox"/> No	Effective Date ____/____/____
Month Day Year	
Medicare Identification # _____	
Is employee still actively employed?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
If no, please enter effective date of retirement/ termination. ____/____/____	
Month Day Year	

CONDITION AND TREATMENT

10. Was condition related to:	
Employment <input type="checkbox"/>	Auto Accident <input type="checkbox"/> Other Accident/Injury <input type="checkbox"/> Illness <input type="checkbox"/>
11. If Accident/Injury, give date.	
____/____/____	
Month Day Year	
12. Describe the nature of accident or illness and list symptoms.	

AUTHORIZATION

I certify that the information I have given is accurate to the best of my knowledge and that I am claiming benefits only for the charges incurred by the patient identified above. I authorize the release of any medical information necessary to process this claim.

Signature _____ Date _____

WHEN SHOULD YOU USE THIS FORM?

This form is designed to help you file itemized medical bills for you or an enrolled family member. You should not submit this form if your healthcare provider has filed a claim for you. Retain your receipt for your records.

PLEASE REVIEW YOUR MEDICAL BILLS AND FILE CLAIMS AT LEAST ONCE A MONTH TO ENSURE THE TIMELY PROCESSING OF YOUR CLAIMS.

CLAIMS FILING INSTRUCTIONS

- 1** Gather All Your **Itemized Medical Bills**
- 2** Separate Your Bills For Each Family Member
- 3** Complete a Separate Claim Form For Each Family Member

- Attach **Itemized Medical Bills** for the patient named on the form. Each itemized bill must include the patient's name, the healthcare provider's name and address, the provider tax id number, the date of each service, procedure codes, descriptions and charge for each service.
- If you are covered under any other health insurance or under Medicare, you must attach a copy of the Explanation of Benefits indicating their payment.

DID YOU

- **** USE A SEPARATE CLAIM FORM FOR EACH FAMILY MEMBER?
- **** COMPLETE EACH SECTION OF THE CLAIM FORM ENTIRELY?
- **** COPY YOUR IDENTIFICATION NUMBER DIRECTLY FROM YOUR ID CARD?
- **** ATTACH THE ORIGINAL ITEMIZED BILL(S) FROM THE PROVIDER THAT DESCRIBES ALL SERVICES RENDERED AND INCLUDES PATIENT'S NAME, HEALTHCARE PROVIDER'S NAME AND ADDRESS, PROVIDER TAX ID NUMBER, DATES OF SERVICE, PROCEDURE CODES, DESCRIPTIONS AND CHARGES?
- **** KEEP A COPY FOR YOUR RECORDS?

Please forward your completed form to:

Blue Cross & Blue Shield of Mississippi
3545 Lakeland Drive
Flowood, Mississippi 39232

For further information or additional copies of this form, please contact our Customer Service Department at 1-800-709-7881.

Claims Administered by:



**BlueCross BlueShield
of Mississippi**

It's good to be Blue.