CareFirst BlueCross BlueShield

Do not write in this space

STATE OF MARYLAND EMPLOYEES HEALTH / VISION PLAN
EMPLOYEE CLAIM FORM

MARYLAND

1.

Subscriber's Legal Name (Last, First, Middle Initial)	**Patient's** Legal Name (Last, First, Middle Initial)
Membership Number	Patient's Sex q Male q Female / Patient's Relationship to Subscriber 1 q Self 2 q Spouse 3 q Child 4 q Other
Subscriber's Address (Street) q Check box if NEW address	Patient's Date of Birth: Month / Date / Year
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 of Service only required for Routine Vision claim submission.

_____ Date _____ Date

_____ Date _____ Date

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

Description of Accident _____

Date of Accident _____ Where Accident Occurred _____

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

4. Does patient have Medicare?

5. a. Medicare Part A (Hospital Insurance)? q Yes q No Effective Date of Coverage ___/___/___ Month Day Year

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

HEALTH INSURANCE CLAIM NUMBER _____

6. In addition to coverage under this program, is patient covered under any other insurance providing health care benefits or services? q Yes q 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: q Hospital q Surgical-Medical q Major Medical q Other (specify) _____

f. Check One: I have q Family q Husband and Wife q Individual q 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 or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or 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

HAVE YOU ATTACHED YOUR ITEMIZED BILLS?

Provider# _____ Initials _____

CareFirst BlueCross BlueShield

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 and receipts required for all services
Keep a copy of your bills and claim for your records
Provider's signature is required (Not required for routine vision)

- 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: (wheelchair, respirator, oxygen, etc.)	Include the full purchase price of any rented equipment. A letter of medical necessity from your 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 sixth visit for outpatient physical therapy, occupational therapy and after first visit for 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
q EXAM	92002/92004 92012/92014		
q FRAME-DISPLAY ☐ YES ☐ NO	V2020		
q SINGLE VISION	V2100-V2114		
q BIFOCAL, SINGLE	V2200-V2214		
q BIFOCAL, DOUBLE	V2799		
q TRIFOCAL	V2300-V2314		
q APHAKIC (LENTICULAR)	V2215		
q CONTACT LENSES (NOT MEDICALLY REQUIRED)	V2503 V2520-V2523		
q CONTACT LENSES (MEDICALLY REQUIRED)	Fitting 92310		

DATE OF CATARACT SURGERY: _____. VISUAL ACCUITY **BEFORE** LENSES:_____. VISUAL ACCUITY **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.

Preferred Provider Option (PPO) Local: 410-581-3601 Toll-Free 1-800-225-0131
Point of Service (POS) Local: 410-581-0021 Toll-Free 1-800-203-2763
Exclusive Provider Organization (EPO) Local: 410-654-8675 Toll-Free 1-800-445-6036
Access our website at **www.carefirst.com/statemd**