Florida Blue

In the pursuit of health®

INSTRUCTIONS FOR FILING A MEDICAL CLAIM — Please read before completing the form on the next page.

1. This form is only needed to submit claims for services and supplies that are not submitted by your provider (i.e., out-of-network doctors and hospitals). You must file your claim within one year from the date of service. You can submit your claim any time during the year.
2. Use a separate claim form for each family member and each physician or supplier.
3. All sections of the form must be filled out completely or your claim may be returned to you.
4. **If your claim is a result of an accident,** please provide a copy of the auto carrier's Explanation of Benefits or Letter of Exhaustion (if available).
5. **If you have other insurance, please provide a copy of your ID card(s).** Please send a copy of Explanation of Benefit statements from the other insurance company for the claim you are submitting (i.e., Medicare, Health, Auto or Workman's Comp).
6. **If your claim is for Durable Medical Equipment** (i.e., wheelchair, respirator, oxygen, etc.), you must submit the prescription along with a letter of medical necessity from the treating physician.
7. **Your original itemized Bills and Receipts must include:**

   ☐ Physician or supplier name

   ☐ Physician or supplier address

   ☐ Physician or supplier Tax ID or NPI (National Provider Identifier) Number

   ☐ Policy Holder (Member) Name

   ☐ Patient's full name

   ☐ Type of service and procedure code

   ☐ Date of service or purchase

   ☐ Diagnosis and diagnosis code

   ☐ Condition being treated

   ☐ Charge for each service

   Important: The following are not acceptable documents: cash register receipts, cancelled checks, money order receipts or personal lists. **You must submit original bills or receipts from your provider. Please keep a copy as the originals cannot be returned.**
8. Please be aware that if the provider or supplier is contracted with Florida Blue, payment will be made to the provider. If this is a contracted provider and you have paid in full for services, you will need to seek reimbursement directly from the provider.
9. If this claim is for a non-contracted provider, payment may be made to you or to the provider. You may sign the AUTHORIZATION OF PAYMENT section to have payment sent directly to the provider.
10. **Please be sure to review your claim form and documents carefully to ensure we can process your claim accurately and quickly.**

MAILING ADDRESS

Please mail your completed claim form with original bills or receipts and copies of other Explanation of Benefits, if applicable to:

Florida Blue
P.O. Box 1798
Jacksonville, FL 32231-0014

MEDICAL CLAIM FORM (To be completed by Member.)

- Complete ALL information or your form may be returned.
- This form only needs to be completed if the physician or supplier is not submitting on your behalf.
- Use a separate form for each family member and each physician or supplier.
- Enclose ORIGINAL itemized bills. Keep a copy for your records.
- Mail to: Florida Blue, PO Box 1798, Jacksonville, FL 32231-0014

See previous page for more instructions.

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MEMBER'S INFORMATION (The policy holder name shown on the front of your ID card.)

Member's Legal Name (Last, First, Middle Initial)			Date of Birth MM / DD / YYYY
Member's Street Address, check box if new address ☐	City	State	Zip Code
Member / Contract Number	Group Number	Employer Name (if applicable)	

PATIENT INFORMATION

Patient's Legal Name (Last, First, Middle Initial)	Date of Birth MM / DD / YYYY
Patient's Relationship to Member ☐ Self ☐ Spouse ☐ Child ☐ Other	Patient's Sex ☐ Male ☐ Female

PATIENT MEDICAL INFORMATION (May be found on Itemized Bill or Receipt)

	Date of Service / Visit (MM / DD / YYYY)	Nature of Visit / Diagnosis Code	Procedure Code(s)	Physician or Supplier Information
1				Name
2				Address
3				Zip Code / Phone Number

Was the treatment the result of an accidental injury? ☐ Yes ☐ No Or work related? ☐ Yes ☐ No

Description of how accident (If accident, include a copy of your auto carrier's Letter of Exhaustion) or work related illness/injury occured: _____

Date of accident or beginning of illness: MM | DD | YYYY

OTHER COVERAGE INFORMATION (If yes, include a copy of your ID card from Medicare or other insurance Co.)

Does patient have Medicare? ☐ Yes ☐ No	Part A (Hospital) ☐ Yes ☐ No	Part B (Physician) ☐ Yes ☐ No	Effective Date of other coverage: MM | DD | YYYY

Is the patient covered under any other insurance policy providing health care benefits or services? ☐ Yes ☐ No

If yes, there is other insurance that is NOT Medicare, please complete a. through c. below:

a. Name on Other Policy:_____

b. Name of Insurance:_____

c. Policy Number: _____

AUTHORIZATION AND SIGNATURE REQUIRED

I certify the above is complete and correct and that I am claiming benefits only for charges incurred by the patient named above. Authorization is hereby given to any hospital, physician, or other provider which participated in any way in my care and treatment to release to Florida Blue any medical information which they in their judgment deem necessary to the adjudication of this claim.
Important: Any person who knowingly and with intent to injure, defraud, or deceive any insurance company files a statement of claim containing any false,incomplete or misleading information is guilty of a felony of the third degree. Florida Statutes, Section 817.234.

Signature of Policy Holder X_____ Date: MM | DD | YYYY

AUTHORIZATION OF PAYMENT TO NON-CONTRACTED PROVIDERS (Signature required if payment is to be sent to the provider(s) above.)

I authorize Florida Blue to make payment of benefits directly to the provider(s) indicated on the enclosed bills/receipts in those situations where such provider(s) is/are non-contracted provider(s) and Florida law requires direct payment when authorized.
Note: Should any such provider also submit a claim for the same services and informs us that the benefits have been assigned, we may honor that assignment should the authorization on this form be signed or not signed.

Signature of Policy Holder X_____ Date: MM | DD | YYYY