

**PLEASE READ THIS IMPORTANT INFORMATION**

**COORDINATION OF BENEFITS?**

If the spouse or the policyholder/patient is covered by another health insurance program, please provide the information requested in Section III.  
 Example: Spouse covered by another insurance company or other Horizon Blue Cross Blue Shield of New Jersey, Inc. coverage.

When submitting charges for services or supplies that have been partially paid or declined by other group health insurance, attach a copy of the Notice of Payment or Explanation of Benefits from the other health care insurer **along with itemized bill(s)**.

**MEDICARE?**

If PATIENT is eligible for Medicare Benefits, be sure you include the Explanation of Medicare Benefits (EOMB) that was sent to patient explaining the charges paid or not paid by Medicare.

To process a claim for you Horizon Blue Cross Blue Shield of New Jersey, Inc., supplementary insurance, we need a copy of the Explanation of Medicare Benefits (EOMB). This EOMB should have been sent to you when Medicare processed your claim. If your EOMB has more than one page, send us copies of all pages. Please write your Horizon Blue Cross Blue Shield identification number clearly on the first page.

**CLAIM FORM WILL BE RETURNED TO YOU IF THIS ADDITIONAL INFORMATION IS NOT SUPPLIED**

An example of an Explanation of Medicare Benefits (EOMB) is displayed below.

**THIS IS NOT A BILL**  
**Explanation of Your Medicare Part B Benefits**

**John Doe**  
 12 Floral Lane  
 Garden City, NJ 08000-0000

Your Medicare number is: **123-45-6789A**      Your provider assigned assignment

Summary of this notice dated XXX XX, XXXX	
Total charges:	\$ 37.00
Total Medicare approved:	\$ 33.23
We paid your provider:	\$ 6.70
Your total responsibility:	\$ 26.53

**Details about this notice (See the back for more information.)**

**BILL SUBMITTED BY:**  
 Mailing Address:

Dates	Services and Service Codes	Charges	Medicare Approved	See Notes Below
XXX XX, XXXX	Control number 80-4138-504-28-00 John R. Jones, M.D. 01 Office/outpatient visit, est (99213)	\$ 37.00		

**Notes:**  
 x The approved amount for this procedure is based on

**IMPORTANT:** If you have any questions about this notice, call. You will need this notice if you contact us. To appeal our decision, you must **WRITE** us before XXXXXXXX XX, XXXX. See #2 on the Back.

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**John Doe**  
 Your Medicare number is: **123-45-6789A**

**More details about this notice**

**General Information About Medicare**

If using a Telecommunications Device for the Deaf (TDD), please call X-XXX-XXX-XXXX for Medicare Part B information.  
 Please note that Medicare now covers flu shots.  
 Do not accept durable medical equipment without discussing the need for such equipment with your physician.  
 If you have questions about this notice, write to us at the following address:  
 Pennsylvania Blue Shield, P.O. Box XXXXXXXXXX, XXXXXXXXXX, XX XXXXX-XXXX  
 If you want to appeal our decision, please write to us at the following address to have this claim reviewed:  
 Medicare Department, XXXXXXX-XXXX.

Medicare approved	\$ 33.23	The provider agreed to accept this amount, See #4 on the back.
Amount applied	- 24.85	You have now met \$ 100.00 of your \$100.00 deductible for XXXX.
Amount less deductible	\$ 8.38	Medicare pays 80% of this total.
Your 20%	- 1.68	You pay 20% of the approved amount.
Amount after deductible and your 20%	\$ 6.70	
Medicare owes	\$ 6.70	
We are paying the provider	\$ 6.70	
Of the approved amount	\$ 33.23	
Less what Medicare owes	- 6.70	
Your total responsibility	\$ 26.53	The provider may bill you for this amount. If you have other insurance, the other insurance may pay this amount.

**IMPORTANT:** If you have any questions about this notice, call. You will need this notice if you contact us. To appeal our decision, you must **WRITE** us before XXXXXXXX XX, XXXX. See #2 on the Back.

**HELPFUL HINTS**

When you are submitting expenses for more than one family member, please use a separate claim form for each person.

It is suggested that you make copies for your own use before you submit the original bills.

Durable medical equipment? (Wheel chair, crutches, braces, oxygen, etc.) Your doctor's certification must be submitted indicating the expected length of time the equipment will be in use. If renting, please have your medical equipment supplier also indicate the purchase price of the equipment on the bill.

Prescription Drugs? Bills must show the prescription number, name and quantity of drug, and the name and address of the pharmacy.

**Please mail completed claim form to:**

**Horizon POS  
 Horizon Blue Cross Blue Shield of New Jersey  
 P.O. Box 820  
 Newark, New Jersey 07101-0820**

FRAUD WARNING  
 ANY PERSON WHO KNOWINGLY FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE OR MISLEADING INFORMATION IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES  
 TO REPORT SUSPECTED FRAUD CALL 1-800-624-2048 AT HORIZON BLUE CROSS BLUE SHIELD OF NEW JERSEY, INC.



Horizon Blue Cross Blue Shield of New Jersey

P.O. Box 820, Newark, New Jersey 07101-0820

(PLEASE TYPE OR PRINT)

# Horizon POS Health Insurance Claim Form

<b>I. POLICYHOLDER</b>	1. POLICYHOLDER'S NAME (Last, First, Middle Initial)		2. POLICYHOLDER'S IDENTIFICATION NUMBER PREFIX (if any)   NUMBER PORTION   SUFFIX (if any)			
	3. POLICYHOLDER'S ADDRESS (No., Street)		CITY	STATE   ZIP CODE		
	4. TELEPHONE NUMBER (Include Area Code) (     )	5. POLICYHOLDER'S SOCIAL SECURITY NUMBER ____-____-____	6. POLICYHOLDER'S BIRTH DATE Month / Day / Year	6a. POLICYHOLDER'S SEX <input type="checkbox"/> Male <input type="checkbox"/> Female		
7. EMPLOYER'S NAME			8. IF THIS IS A GROUP POLICY, INDICATE THE GROUP NUMBER			
<b>II. PATIENT</b>	9. PATIENT'S NAME (Last, First, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO:			
	11. PATIENT'S BIRTH DATE Month / Day / Year	11a. PATIENT'S SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	12. PATIENT STATUS <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Other	a. EMPLOYMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT <input type="checkbox"/> YES <input type="checkbox"/> NO c. OTHER ACCIDENT <input type="checkbox"/> YES <input type="checkbox"/> NO		
	13. PATIENT'S RELATIONSHIP TO POLICYHOLDER <input type="checkbox"/> Policy Holder <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other		14. IS PATIENT <input type="checkbox"/> Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student	d. DATE OF ACCIDENT: Month / Day / Year DATE OF YOUR FIRST SYMPTOM OF ILLNESS: Or, if Pregnant, Date of your Last Menstrual Period: Month / Day / Year		
<b>III. COORDINATION OF BENEFITS</b>	15. DOES THE PATIENT HAVE OTHER HEALTH INSURANCE? <input type="checkbox"/> YES <input type="checkbox"/> NO		IF YES, COMPLETE ITEMS 15a-h AND SEE INSTRUCTIONS ON BACK		15a. IF MEDICARE, CHECK HERE AND ATTACH EOMB <input type="checkbox"/> (See instructions and example of EOMB on back)	
	15b. OTHER POLICYHOLDER'S NAME (Last, First, Middle Initial)		15c. OTHER POLICYHOLDER'S BIRTH DATE Month / Day / Year	15d. OTHER POLICYHOLDER'S SEX <input type="checkbox"/> Male <input type="checkbox"/> Female		
	15e. OTHER POLICYHOLDER'S ADDRESS (No., Street)		CITY	STATE	ZIP CODE	
	15f. OTHER INSURANCE PLAN'S NAME		15g. OTHER POLICYHOLDER'S IDENTIFICATION NUMBER AND GROUP NUMBER			
	15h. OTHER INSURANCE PLAN'S ADDRESS (No., Street)		CITY	STATE	ZIP CODE	
<b>IV. AUTHORIZATION</b>	16. I certify that the information provided on this claim form is correct and complete, and that I am claiming benefits only for charges actually incurred by the patient named. I authorize any hospital, physician or other provider who participated in the care and treatment of the patient to release to Horizon Blue Cross Blue Shield of New Jersey, Inc., all medical or other information requested for the processing of this claim form. I hereby agree to reimburse Horizon Blue Cross Blue Shield of New Jersey, Inc., in full should this claim be incorrectly paid.					
AUTHORIZED SIGNATURE		DATE	(AREA CODE) HOME PHONE	(AREA CODE) WORK PHONE		

**WHEN YOU ARE SUBMITTING EXPENSES FOR MORE THAN ONE FAMILY MEMBER, PLEASE USE A SEPARATE CLAIM FORM FOR EACH PERSON.**

**ITEMIZED BILLS FOR COVERED SERVICES OR SUPPLIES MUST BE ATTACHED TO THIS FORM AND INCLUDE THE FOLLOWING:**

Check that each itemized bill is legible and contains ALL of the following information:

- NAME & ADDRESS of person or institution rendering the service or supplying the item
- PROVIDER'S Federal Tax Identification Number
- PATIENT'S FULL NAME
- TYPE of service rendered or item supplied
- DATE each service rendered or item supplied
- AMOUNT charged for each service rendered or item supplied
- DIAGNOSIS of ailment

**BILLS MISSING ANY OF THIS INFORMATION WILL DELAY PROCESSING AND MAY BE RETURNED TO YOU**

Cash register receipts, cancelled checks, money order receipts, personal itemizations, and bills only noting a "balance due" are not acceptable.

**SEE BACK OF THIS FORM FOR IMPORTANT INFORMATION**