

PLEASE DO NOT STAPLE IN THIS AREA



1400 S. Boston | P.O. Box 21128 | Tulsa, OK 74121-1128

1-800-580-6202

HEALTH INSURANCE CLAIM FORM

PATIENT INFORMATION

PLEASE PRINT OR TYPE

LAST NAME OF PATIENT	FIRST	MIDDLE INITIAL	SEX <input type="checkbox"/> M <input type="checkbox"/> F	DATE OF BIRTH MM/DD/YY	RELATIONSHIP TO MEMBER	MARITAL STATUS <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced/Separated
PATIENT'S ADDRESS (STREET, CITY, STATE, ZIP CODE)						PATIENT'S TELEPHONE (INCLUDE AREA CODE)
IS PATIENT'S CONDITION RELATED TO: <i>(Please check one)</i> <input type="checkbox"/> Employment (current or previous) <input type="checkbox"/> Auto accident (state where accident occurred: _____) <input type="checkbox"/> Other				EMPLOYMENT STATUS <input type="checkbox"/> Employed full time <input type="checkbox"/> Employed part time <input type="checkbox"/> Full-time student <input type="checkbox"/> Part-time student		
<b>READ BACK OF FORM BEFORE COMPLETING &amp; SIGNING</b> PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED: _____ DATE: _____						

MEMBER INFORMATION

LAST NAME OF MEMBER	FIRST	MIDDLE INITIAL	SEX <input type="checkbox"/> M <input type="checkbox"/> F	DATE OF BIRTH MM/DD/YY	I.D. NUMBER	POLICY GROUP OR FECA NUMBER
MEMBER'S TELEPHONE NUMBER (INCLUDE AREA CODE)		EMPLOYER			INSURANCE PHONE NUMBER	
INSURED OR AUTHORIZED PERSON'S SIGNATURE: I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED: _____ DATE: _____						

OTHER INSURANCE INFORMATION

DOES PATIENT HAVE OTHER HEALTH INSURANCE? <input type="checkbox"/> Yes <input type="checkbox"/> No	COVERAGE IS: <input type="checkbox"/> Single <input type="checkbox"/> Family	POLICY HOLDER'S NAME		DATE OF BIRTH MM/DD/YY	SEX <input type="checkbox"/> M <input type="checkbox"/> F
OTHER INSURANCE CARRIER'S NAME	POLICY NUMBER	I.D. NUMBER	EMPLOYER	INSURANCE PLAN/PROGRAM NAME	

PHYSICIAN/SUPPLIER INFORMATION (TO BE COMPLETED BY TREATING PHYSICIAN OR SUPPLIER)

DATE OF CURRENT ILLNESS (FIRST SYMPTOMS) INJURY (ACCIDENT) OR PREGNANCY (LMP):	MM/DD/YY	HAS PATIENT HAD SAME OR SIMILAR ILLNESS? IF YES, PROVIDE FIRST DATE OF OCCURRENCE:	DATES PATIENT WAS UNABLE TO WORK: (MM/DD/YY) FROM: TO:		
OUTSIDE LAB USED? <input type="checkbox"/> Yes <input type="checkbox"/> No	OUTSIDE LAB CHARGES: \$	MEDICAID RESUBMISSION CODE	ORIGINAL REFERENCE NO.	PRIOR AUTHORIZATION NUMBER	

DIAGNOSIS OR NATURE OF ILLNESS OR INJURY

DIAGNOSIS:					
DATE OF SERVICE: FROM: TO:	MM/DD/YY	PLACE OF SERVICE	TYPE OF SERVICE	PROCEDURES/SERVICES/SUPPLIES (EXPLAIN UNUSUAL CIRCUMSTANCES) CPT/HCPCS: MODIFIER:	DIAGNOSIS CODE \$ CHARGES
DIAGNOSIS:					
DATE OF SERVICE: FROM: TO:	MM/DD/YY	PLACE OF SERVICE	TYPE OF SERVICE	PROCEDURES/SERVICES/SUPPLIES (EXPLAIN UNUSUAL CIRCUMSTANCES) CPT/HCPCS: MODIFIER:	DIAGNOSIS CODE \$ CHARGES
DIAGNOSIS:					
DATE OF SERVICE: FROM: TO:	MM/DD/YY	PLACE OF SERVICE	TYPE OF SERVICE	PROCEDURES/SERVICES/SUPPLIES (EXPLAIN UNUSUAL CIRCUMSTANCES) CPT/HCPCS: MODIFIER:	DIAGNOSIS CODE \$ CHARGES

FEDERAL TAX I.D. NUMBER <input type="checkbox"/> SSN <input type="checkbox"/> EIN	PATIENT'S ACCOUNT NO.	ACCEPT ASSIGNMENT (GOV'T CLAIMS, SEE BACK) <input type="checkbox"/> YES <input type="checkbox"/> NO	TOTAL CHARGE \$	AMOUNT PAID \$	BALANCE DUE \$
SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS <i>I certify that the statements on the reverse apply to the bill and are made a part thereof.</i>		NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (IF OTHER THAN HOME OR OFFICE)		PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE NUMBER	
SIGNED: _____ DATE: _____				PIN NUMBER	GRP:

## HOW TO FILE CLAIMS

Please note: These instructions assume that your provider of medical services will not be directly filing a claim with BlueLincs for the services rendered to you and your dependents and therefore you are choosing to file your own claims. All services must be authorized, in advance, by your primary care physician or BlueLincs.

1. Complete the "Patient and Member Information" sections on the claim form. If you wish to have your medical benefits paid directly to your doctor, be sure to sign the Member signature line. A separate form should be submitted for each family member.
2. Have your doctor complete the "Physician/Supplier Information" section or submit completely itemized bills. An itemized bill is one that shows the patient's name, relationship, date of service, the type of service rendered and the nature of the condition being treated, and the physician's taxpayer identification number, if benefits are assigned.

Send the claim form:  
BlueLincs HMO  
P.O. Box 21318  
Tulsa, OK 74121-1318

If you have questions or need claim  
forms, please call:  
1-800-580-6202

### IMPORTANT REMINDER:

- Have you remembered to include your member number?
- Completely itemized bills showing the nature of illness or injury are required.
- Failure to complete requested information may result in a delay in processing this claim.
- Either the physician or the member (not both) should submit a claim.

If your provider is filing or will file the claim for you, it is not necessary for you to file a duplicate claim. Please advise your provider to send the claims to BlueLincs at the address above.