BlueCross BlueShield of Oklahoma

Supplemental Health Wellness Benefit Claim Form

Return to Blue Cross and Blue Shield of Oklahoma at:
Attention: Claims Department
P.O. Box 7070
Downers Grove, IL 60515

Phone Number: (888) 381-9727
Fax: (855) 645-8242

Employee Name _____ (Last) _____ (First)

Check all that apply:

☐ Accident ☐ Critical Illness ☐ Hospital Indemnity

Employee Information — To be completed by Employee

Group Number		Group Name		
Name	Last	First	Middle	Date of Birth
Address	Street	City	State	Zip
Social Security No.		E-mail Address		

Patient Information

☐ Same as Employee ☐ Child ☐ Spouse

Name	Last	First	Middle	Date of Birth
Address	Street	City	State	Zip
Social Security No.		Phone Number	E-mail Address	

Health Screening Information — To be completed by Employee

Test/Procedure	Date	Test/Procedure	Date
☐ Stress test on bicycle or treadmill		☐ Colonoscopy	
☐ Serum Cholesterol Test (HDL AND LDL)		☐ Thermography	
☐ CA 15-3 (Blood test for Breast Cancer)		☐ Serum Protein Electrophoresis (Myeloma)	
☐ Chest X-Ray		☐ Mammography	
☐ Hemocult Stool Analysis		☐ Blood test for triglycerides	
☐ PSA (Blood test for prostate cancer)		☐ Carotid Doppler	
☐ Fasting Blood Glucose Test		☐ CEA (Blood test for colon cancer)	
☐ Bone Marrow aspiration or biopsy		☐ Flexible Sigmoidoscopy	
☐ CA 125 (Blood test for ovarian cancer)		☐ Pap Smear (Women over age 18)	
☐ Echocardiogram		☐ Electrocardiogram	
☐ Fasting Plasma Glucose (FPG)		☐ Hemoglobin A1c (HbA1c)	
☐ Skin Cancer Biopsy		☐ Thin Prep Pap Test	
☐ Two Hour Post-load Plasma Glucose		☐ Virtual Colonoscopy	
☐ COVID-19 test		☐ Vaccinations	

Please attach documentation, including an itemized bill, showing the provider, patient's name, date of the service and name of exam performed.

Signature of Employee _____

Print Name _____ Date _____

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Employee Name

Last _____ First _____

AUTHORIZATION FOR RELEASE OF INFORMATION (We will require a separate authorization for release of psychotherapy notes.)

I authorize physician, medical professional, pharmacist or other provider of health **care** services, hospital, clinic, other medical or medically related facility; coroner's office; insurance or reinsurance **company**; government agency; department of labor; law enforcement or public safety department; group policyholder; employer; or policy or benefit plan administrator to release **information** from the **records** of:

Patient's Name: _____ Last _____ First _____ Middle _____ Date of Birth

Patient Information to be released:

- Data or records regarding medical history, treatment, prescriptions, consultations, autopsy (including medical reports; records, charts, notes (excluding psychotherapy notes), x-rays, films or correspondence, and any medical condition(s));
- Any information regarding insurance coverage; and
- Accident report or any official investigative reports (such as police, fire, FAA, OSHA, or toxicology report).
- Information to be released to:

  Blue Cross and Blue Shield of Oklahoma
  P.O. Box 7070
  Downers Grove, IL 60515

- I understand the information obtained by use of this Authorization will be used by The Company to evaluate my claim for benefits. The Company will only release such information:
  - To its reinsurer, or other persons or organizations performing business or legal services in connection with my claim(s); or
  - As may be required by law; or
  - As I further authorize.
- I further understand that refusal to sign this Authorization may result in the denial of benefits.
- I understand the information used or disclosed may be subject to re-disclosure by the recipient and may no longer be protected by federal law.
- I understand that I may revoke this Authorization in writing at any time, except to the extent The Company has taken action in reliance on this Authorization. If written revocation is not received, this Authorization will be considered valid for a period of time not to exceed 24 months from the date of signature below. To initiate revocation of this Authorization, direct all correspondence to The Company at the above address.
- A photocopy of this Authorization is to be considered as valid as the original.
- I understand I am entitled to receive a copy of this signed Authorization.

Signature (Patient or Representative) _____

Print Name _____ Date _____

If you are the legal representative of the Patient we may ask for additional documentation.

Address: _____ Street _____ City _____ State _____ Zip

Phone No. _____

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Employee Name _____ _____
Last First

OPTIONAL - DISCLOSING INFORMATION TO THIRD PARTIES

You are not required to sign this Optional Authorization. However, if you would like us to communicate with a family member, friend or other third party about your claim, we recommend completing the information below. Please sign and date the form as indicated and mail or fax it to the address or fax number indicated above.

Optional Authorization to Disclose Information to Third Parties

To assist in the evaluation or administration of my claim(s), I authorize The Company to share personal health and financial information relating to my claim with the family members, friends, and/or other third parties listed below:

My Spouse: _____ _____ _____
Last First Middle

Other Family Member: _____ _____ _____
Last First Middle

_____
Relationship

Other Person: _____ _____ _____
Last First Middle

_____

I authorize The Company to leave messages about my claim on my voicemail / answering machine. ☐Yes ☐No

I understand that information about my claim may include information about my health and that such information about my health may be related to any disorder of the immune system including, but not limited to, HIV and AIDS; use of drugs and alcohol; and mental and physical history, condition, advice or treatment, but does not include psychotherapy notes.

I may revoke this authorization in writing at any time except to the extent The Company or the authorized recipient of my information has relied on it prior to receiving my notice of revocation. I may revoke this Authorization by sending written notice to the address above.

This authorization is valid for the shorter of two (2) years or the duration of my claim. I may request a copy of the Authorization and a copy shall be as valid as the original.

Signature (Patient) _____

Print Name _____ Date _____

I signed on behalf of the patient as _____(indicate relationship)

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BlueCross BlueShield of Oklahoma

Fraud Notices

Administrative Office: 701 E. 22nd Street, Lombard, Illinois 60148

The laws of some states require us to furnish you with the following notice:

FOR APPLICATIONS AND CLAIMS:

Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

California: For your protection California law requires the following to appear on this form. Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

District of Columbia: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Hawaii: For your protection, Hawaii law requires you be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Maryland: Any person who knowingly or willingly 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.

New Mexico: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

Ohio: Any person who, with intent to defraud or knowingly that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Oklahoma: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing false, incomplete or misleading information is guilty of a felony.

Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Puerto Rico: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances be present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

Rhode Island: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Tennessee: It is a crime to knowingly provide false incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Washington: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

West Virginia: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

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The laws of some states require us to furnish you with the following notice:

FOR CLAIMS ONLY:

Alaska: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

Arizona: For your protection, Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

Arkansas: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Delaware: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

Idaho: Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing false, incomplete, or misleading information is guilty of a felony.

Indiana: A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

Minnesota: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

New Hampshire: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in NH RSA 638:20.

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

Texas: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

FOR APPLICATIONS ONLY:

New Jersey: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.