P.O. Box 1609
Newark, New Jersey 07101-1609

Horizon Blue Cross Blue Shield of New Jersey

(PLEASE TYPE OR PRINT)

Health Insurance Claim Form

I. POLICYHOLDER

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 — ☐ Male ☐ Female

7. EMPLOYER'S NAME

8. IF THIS IS A GROUP POLICY, INDICATE THE GROUP NUMBER

II. PATIENT

9. PATIENT'S NAME (Last, First, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

a. EMPLOYMENT? (Current or Previous) ☐ YES ☐ NO

b. AUTO ACCIDENT ☐ YES ☐ NO — STATE IN WHICH AUTO ACCIDENT OCCURRED: ______

c. OTHER ACCIDENT ☐ YES ☐ NO

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

11. PATIENT'S BIRTH DATE — Month / Day / Year

11a. PATIENT'S SEX — ☐ Male ☐ Female

12. PATIENT STATUS — ☐ Married ☐ Single ☐ Other

13. PATIENT'S RELATIONSHIP TO POLICYHOLDER — ☐ Policy Holder ☐ Spouse ☐ Child ☐ Other

14. IS PATIENT — ☐ Employed ☐ Full-Time Student ☐ Part-Time Student

III. COORDINATION OF BENEFITS

15. DOES THE PATIENT HAVE OTHER HEALTH INSURANCE? ☐ YES ☐ NO

IF YES, COMPLETE ITEMS 15a-h AND SEE INSTRUCTIONS ON BACK

15a. IF MEDICARE, CHECK HERE AND ATTACH EOMB ☐
(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 — ☐ Male ☐ 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

IV. AUTHORIZATION

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.

17. AUTHORIZATION FOR ASSIGNMENT OF BENEFITS
Horizon Blue Cross Blue Shield of New Jersey, Inc., at its discretion, may accept an Assignment of Benefits. I the undersigned, authorize and request Horizon Blue Cross Blue Shield of New Jersey Inc., to make payment for benefits which may be due herein to:

NAME OF PROVIDER — PROVIDER'S TAX OR SOCIAL SECURITY NUMBER — SIGNATURE OF POLICYHOLDER — DATE

An Independent Licensee of the Blue Cross and Blue Shield Association

SEE BACK OF THIS FORM FOR IMPORTANT INFORMATION