Nebraska Comprehensive Health Insurance Pool

Administered by Blue Cross and Blue Shield of Nebraska, An Independent Licensee of the Blue Cross and Blue Shield Association.

P.O. Box 3248 Omaha, Nebraska 68180-0001 390-1814 (Omaha Area) 1-800-356-3485 (Toll Free)

CLAIM FORM

Dear Subscriber:

In order to properly and accurately process your claim, this form must be filled out completely. A claim form must be completed for each year for which your are requesting benefits. Please check to make sure that each section of this form is completed. If any items are omitted, we will have to return your claim for completion. It is our desire to process your claim with the utmost accuracy.

Please refer to the claim filing instructions on the reverse side.

Subscriber's Name ______________________________ Identification Number ______________________
Last First Middle

Home Address ____ ☐ Check if new address
Street City State Zip

Date of Birth ______________________ Time ______ ☐ a.m. ☐ p.m.
Month Day Year

Diagnosis ____

Were any of the above conditions caused by an accident? ☐ Yes ☐ No If Yes, please complete the following:

Type of accident (automobile, sports, etc.): ______________________________

Date and time of accident: Date ______________ 19 ____

Were you injured at work? ☐ Yes ☐ No If Yes, give name and address of employer:

____

____

Are you covered under any other health benefits plan held by reason of law or employment? ☐ Yes ☐ No If Yes, please answer the following:

____
Name of other insurance company

____
Address of other insurance company

I certify that the above is complete and correct and that I am claiming benefits only for charges incurred.

______________________________ ______________
Signature of Subscriber Date

(Itemized bills cannot be returned. If you wish to retain copies, please make your copies prior to submitting claim.)

Claim Filing Instructions

1. Check with the provider of care to be sure a claim has not been submitted. Duplicate claims will be denied and could also delay payment of the original claim.
2. Complete (type or print) the claim form in full.
3. Attach itemized statement(s). All itemized statements (receipts) must be on the provider's letterhead and must contain the following:
   a. Subscriber's name.
   b. Provider of service (name and address).
   c. Type of service performed or name(s) of drug(s).
   d. Charge for each service.
   e. Date (month, day, year) for each service).

   For medical equipment, the following information is needed in addition to the above:

   f. Name or description of the equipment item.
   g. Copy of the physician's order for the equipment.
   h. Rental period (if purchase cost would be more economical than rental, contact our office for ***advance*** authorization).
   i. Rental charge.
4. Please sign and date the form.

Form Completion

Subscriber's name — Enter name exactly as shown on your identification card.

Identification number — Write identification number (not the group number) exactly as shown on your identification card.

Home address — Enter subscriber's complete address, city, state and zip code. Be sure to check the box if this is a new address.

Date of birth — Enter subscriber's exact date of birth (month, day and year).

Diagnosis — Give all appropriate diagnoses or reason(s) why the care was received.

Were any of the above conditions caused by an accident? — Check ☑ only one.

Type of accident — Explain how accident happened.

Date and time of accident — Give exact date of accident (month, day, and year), time of accident and check ☑ a.m. or p.m.

Are you covered under any other health benefits plan held by reason of law or employment? — Check ☑ Yes or No. If Yes, give name of other insurance company and address.