HORIZON MEDICAL HEALTH INSURANCE CLAIM FORM

PLEASE READ THIS IMPORTANT INFORMATION

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
- ☑ Health Care Professional Federal Tax Identification Number (Required)
- ☑ Health Care Professional NPI Number
- ☑ PATIENT'S FULL NAME
- ☑ TYPE of service rendered/produced or item supplied
- ☑ DATE each service rendered or item supplied
- ☑ AMOUNT charged for each service rendered or item supplied
- ☑ DIAGNOSIS of ailment

MEMBER WILL BE NOTIFIED OF BILLS MISSING ANY OF THIS INFORMATION.

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

Note that by completing Box 28 payment will go directly to the Provider.

COORDINATION OF BENEFITS?

If you or your covered dependent(s) are 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 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 your Horizon Blue Cross Blue Shield of New Jersey, 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 of New Jersey identification number clearly on the first page.

CLAIM WILL REJECT IF THIS INFORMATION IS NOT SUPPLIED.

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.

Prescription Drugs? Bills must show the patient's name and date of service, prescription number and amount paid, name, strength & quantity of drug and the name and address of the pharmacy.

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.

Please mail completed claim form to:

Horizon Blue Cross Blue Shield of New Jersey
P.O. Box 1609
Newark, New Jersey 07101-1609

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

Horizon

You may complete the required fields below online and then save or print a copy for submission. To save a completed copy to your computer, choose File > Save As to rename the file and save the form with your information to your computer.

Reset Form

Horizon Medical Health Insurance Claim Form

THIS FORM CAN BE DOWNLOADED FROM OUR WEB SITE AT www.HorizonBlue.com

Please Print This Form In Color (If Available).

INSURED'S INFORMATION

1. LAST NAME | FIRST NAME | MI

2. DATE OF BIRTH (MM / DD / YYYY) | 3. SEX (M / F) | 4. IDENTIFICATION NUMBER (Prefix (if any) / Number Portion)

6. ADDRESS (No., Street) | CITY | STATE | ZIP CODE

7. TELEPHONE NUMBER (Include Area Code) | 8. EMPLOYER'S NAME

9. INSURANCE PLAN NAME OR PROGRAM NAME

10. IS THERE ANOTHER INSURANCE PLAN? (No / Yes) **IF YES, COMPLETE ITEMS 20 - 26**

PATIENT'S INFORMATION (If Patient is the same as the Insured, please skip to #16)

11. LAST NAME | FIRST NAME | MI

12. DATE OF BIRTH (MM / DD / YYYY) | 13. SEX (M / F) | 14. TELEPHONE NUMBER (Include Area Code)

15. ADDRESS (No., Street) | CITY | STATE | ZIP CODE

16. RELATIONSHIP TO INSURED (Self / Spouse/DP / Child / Other) | 17. PATIENT'S STATUS (Single / Married / Other) | EMPLOYED | FULL-TIME STUDENT | PART-TIME STUDENT

18. IS PATIENT'S CONDITION RELATED TO:
a. EMPLOYMENT? (Current or Previous) (No / Yes) | b. AUTO ACCIDENT? (No / Yes) | PLACE (State) | C. OTHER ACCIDENT (No / Yes)

19. DATE OF CURRENT ILLNESS (MM / DD / YYYY) **ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)**

OTHER INSURANCE INFORMATION

20. LAST NAME OF POLICY HOLDER | FIRST NAME | MI

21. DATE OF BIRTH (MM / DD / YYYY) | 22. SEX (M / F) | 23. IDENTIFICATION NUMBER

24. TELEPHONE NUMBER (Include Area Code) | 25. EMPLOYER'S NAME OR SCHOOL NAME

26. INSURANCE PLAN NAME OR PROGRAM NAME

AUTHORIZATION

27. 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 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, in full should this claim be incorrectly paid.

SIGNATURE OF PATIENT (unless a minor) | DATE

28. AUTHORIZATION FOR ASSIGNMENT OF BENEFITS
Horizon Blue Cross Blue Shield of New Jersey, at its discretion, may accept an Assignment of Benefits. I the undersigned, authorize and request Horizon Blue Cross Blue Shield of New Jersey, to make payment for benefits which may be due herein to: **Payment will be sent to the Provider if this section is completed.**

NAME OF HEALTH CARE PROFESSIONAL | TAX NUMBER (Required) | NPI NUMBER

SIGNATURE OF INSURED | DATE

SEE BACK OF THIS FORM FOR IMPORTANT INFORMATION