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TION	OUNTS HEALTH INSURAN	,	PICA
. MEDICARE MEDICAID TRICARE CHAMP'S (Medicare #) (Medicaid #) (Sponsor's SSN) (Member	— HEALTH PLAN — BLK LUNG —	1a. INSURED'S I.D. NUMBER PREFIX (if any) NUMBER PORTION (Fo	r Program in Item 1)
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) 3. PATIENT'S BIRTH DATE SEX MM DD YY M F		4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
5. PATIENT'S ADDRESS (No., Street) 6. PATIENT RELATIONSHIP TO INSURED		7. INSURED'S ADDRESS (No., Street)	
Self Spouse Child Other		CITY STATE	
	Single Married Other		
P CODE TELEPHONE (Include Area Code)	Full-Time Part-Time	ZIP CODE TELEPHONE (Incl	ude Area Code)
OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	Employed Student Student 10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER	R
			057
OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous)	a. INSURED'S DATE OF BIRTH MM DD YY M M	SEX F
OTHER INSURED'S DATE OF BIRTH SEX	b. AUTO ACCIDENT? PLACE (State)	b. EMPLOYER'S NAME OR SCHOOL NAME	
EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT?	c. INSURANCE PLAN NAME OR PROGRAM NAME	
INSURANCE PLAN NAME OR PROGRAM NAME	YES NO GRAM NAME 10d. RESERVED FOR LOCAL USE d. IS THERE ANOTHER HEALTH BENEFIT PLAN?		
. INSURANCE PLAN NAME OR PROGRAM NAME 10d. RESERVED FOR LOCAL USE		YES NO If yes, return to and complete item 9 a-d.	
READ BACK OF FORM BEFORE COMPLETIN PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the to process this claim. I also request payment of government benefits eithe below.	release of any medical or other information necessary	INSURED'S OR AUTHORIZED PERSON'S SIGN payment of medical benefits to the undersigned pt services described below.	
SIGNED DATE		SIGNED	
DATE OF CURRENT: ILLNESS (First symptom) OR MM DD YY INJURY (Accident) OR 15.	IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRE MM DD YY MM FROM ! YOU TO	i i
7. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. 17b. NPI		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY TO YY	
9. RESERVED FOR LOCAL USE 11. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)		20. OUTSIDE LAB? \$ CHARGES YES NO 22. MEDICAID RESUBMISSION ORIGINAL REF. NO.	
4			
	EDURES, SERVICES, OR SUPPLIES ain Unusual Circumstances) PCS MODIFIER POINTER	F. G. H. I. DAYS EPSDT ID. OR Family ID. \$ CHARGES UNITS Plan QUAL.	J. RENDERING PROVIDER ID. #
		NPI NPI	
		NPI	
		NPI NPI	
		NPI NPI	
FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S	(For govt. claims, see back)	28. TOTAL CHARGE 29. AMOUNT PAID \$	30. BALANCE DUE
SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	YES NO	33. BILLING PROVIDER INFO & PH # (<u> </u>

PLEASE READ THIS IMPORTANT INFORMATION

COORDINATION OF BENEFITS?

If the spouse or the policyholder/patient is 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, Inc. 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).

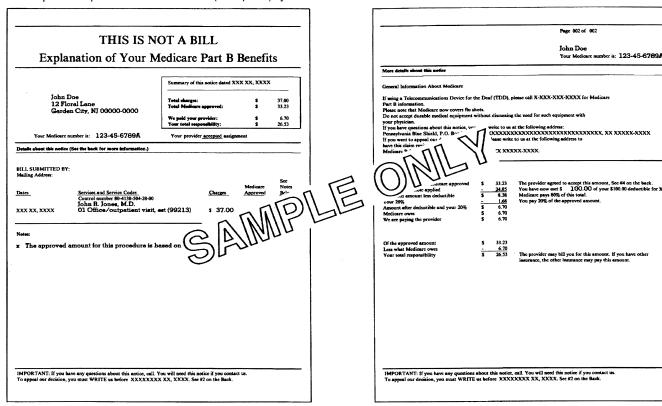
MEDICARE?

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, Inc., 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, Inc. identification number clearly on the first page.



An example of an Explanation of Medicare Benefits (EOMB) is displayed below.



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 1219 Newark, New Jersey 07101-1219

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, INC.