



**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.

**CLAIM FORM WILL BE RETURNED TO YOU IF THIS ADDITIONAL INFORMATION IS NOT SUPPLIED**

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

**THIS IS NOT A BILL**  
**Explanation of Your Medicare Part B Benefits**

John Doe  
 12 Floral Lane  
 Garden City, NJ 08000-0000

Your Medicare number is: 123-45-6789A

Your provider accepted assignment

Summary of this notice dated XXX XX, XXXX	
Total charges:	\$ 37.00
Total Medicare approved:	\$ 33.23
We paid your provider:	\$ 6.70
Your total responsibility:	\$ 26.53

**Details about this notice (See the back for more information.)**

**BILL SUBMITTED BY:**  
 Mailing Address:

Date	Services and Service Codes	Charges	Medicare Approved	See Notes Below
XXX XX, XXXX	01 Office/outpatient visit, set (99213) John R. Jones, M.D. Control number 80-4138-504-28-00	\$ 37.00		

**Note:**  
 x The approved amount for this procedure is based on

**IMPORTANT:** If you have any questions about this notice, call. You will need this notice if you contact us. To appeal our decision, you must WRITE us before XXXXXXXX XX, XXXX. See #2 on the Back.

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John Doe  
 Your Medicare number is: 123-45-6789A

**More details about this notice**

**General Information About Medicare**

If using a Telecommunications Device for the Deaf (TDD), please call 1-800-XXX-XXXX for Medicare Part B information.  
 Please note that Medicare now covers flu shots.  
 Do not accept durable medical equipment without discussing the need for such equipment with your physician.  
 If you have questions about this notice, write to us at the following address:  
 Pennsylvania Blue Shield, P.O. Box XXXXXXXX, XX XXXXX-XXXX  
 If you want to appeal our decision, write to us at the following address to have this claim reviewed:  
 Medicare, P.O. Box XXXXX-XXXX

**Medicare approved** \$ 33.23  
**Amount applied** - 24.85  
**Amount less deductible** \$ 6.38  
**Your 20%** - 1.65  
**Amount after deductible and your 20%** \$ 6.70  
**Medicare owes** \$ 6.70  
**We are paying the provider** \$ 6.70

The provider agreed to accept this amount. See #4 on the back.  
 You have now met \$ 100.00 of your \$100.00 deductible for XXXX.  
 Medicare pays 80% of this total.  
 You pay 20% of the approved amount.

**Of the approved amount** \$ 33.23  
**Less what Medicare owes** - 6.70  
**Your total responsibility** \$ 26.53

The provider may bill you for this amount. If you have other insurance, the other insurance may pay this amount.

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**SAMPLE ONLY**

**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

**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, INC.