STATE HEALTH PLAN COMPREHENSIVE BENEFITS CLAIM FORM

South Carolina State Budget and Control Board, Employee Insurance Program

To file a claim, complete and sign this form. You must attach copies of itemized bills, including diagnoses, to receive proper payment for your claim.

1 Insured's Name ____________________ I.D.# **ZCS** ____________________

2 Patient's Name ____________________
First Middle Initial Last

3 The patient is: ☐ Female ☐ Male
The patient is the: ☐ Insured ☐ Insured's Spouse ☐ Insured's Child

4 Patient's Date of Birth ____________________
Month Day Year

5 Insured's Mailing Address ____________________
Street City State ZIP Code

6 Was the treatment required as a result of accidental injury? ☐ Yes ☐ No If yes, give date of accident ________

7

MEDICARE INFORMATION

Is the patient covered by Medicare? ☐ Yes ☐ No If yes, give date of Medicare No. ________

If yes, does the patient have Medicare Part A (Hospital Benefits)?

☐ Yes ☐ No Date coverage became effective _____/ ____/ ____

If yes, does the patient have Medicare Part B (Medical Surgical Benefits)?

☐ Yes ☐ No Date coverage became effective ____/ ____/ ____

Is patient entitled to Medicare because of ESRD? ☐ Yes ☐ No

Is patient actively working? ☐ Yes ☐ No

Is the patient disabled? ☐ Yes ☐ No

Is the patient retired? ☐ Yes ☐ No

If yes, give the date of retirement ____/ ____/ ____

8

OTHER GROUP INSURANCE COVERAGE

Is the patient covered under any other health benefit plan? ☐ Yes ☐ No

If yes, you must complete this section so your claims can be processed.

A. Name of other insurance company ____________________
Address of other insurance company ____________________

B. Name of insured under this policy (policyholder) ____________________
Relationship to patient ____________________
Insured's date of birth ____________________

C. Effective date of other insurance policy ____________________
Policy number of other insurance policy ____________________

Always attach your Explanation of Benefits or explanation of payment from your other plan.

9

CERTIFICATION OF MEMBER

I certify that the above information is correct and that the foregoing expenses were incurred for the above-named patient. I authorize any physician, nurse, hospital or other provider or supplier in possession of records or information concerning the patient to furnish such information to BlueCross BlueShield of South Carolina upon request.

INSURED'S SIGNATURE ____________________ DATE ____________

(11318) Rev. 8/09

Please see the other side of this form for mailing instructions.

Please send this form to:

BlueCross BlueShield of South Carolina
P.O. Box 100605
Columbia, SC 29260-0605

In Columbia: 803-736-1576
In S.C. and Nationwide: 800-868-2520

Before you mail your claim form, please remember to:

1. **Include the insured's State Health Plan Policy number;**
2. **Sign and date the form; and**
3. **Attach copies of itemized bills for services.**

BlueCross BlueShield of South Carolina is an independent licensee of the Blue Cross and Blue Shield Association.