Medical claim submission form

A separate claim form must be submitted for each patient when sending bills to BlueAdvantage Administrators of Arkansas

Employer name & division number	Member ID

Patient's information

Patient's first name	Middle initial	Last name	Date of birth (mm/dd/yyyy)

Gender	Patient's relationship to policy/certificate holder
☐ Male ☐ Female	☐ Self ☐ Spouse ☐ Child ☐ Other (Specify)

Description of illness or injury requiring treatment	Date illness began

Was this an accident?	If yes, date of accident	Was this an automobile accident?	Was this related to employment?
☐ Yes ☐ No		☐ Yes ☐ No	☐ Yes ☐ No

Employee information

Employee's first name	Middle initial	Last name

ASSIGNMENT - Payment for this claim should be made to:
☐ Hospital ☐ Doctor ☐ Employee

Employee address	City	State	ZIP

I hereby authorize any insurance company, prepayment organization, employer, hospital, or physician, to release all information with respect to myself or any of my dependents which may have a bearing on the benefits payable under this or any other plan providing benefits or services. I certify that the above information in support of this claim is true and correct.

Other insurance

Do you have other health insurance with a group or government program?

☐ Yes (Please complete section below) ☐ Yes, Medicare A
☐ No ☐ Yes, Medicare B

If Medicare, reason for coverage
☐ 65+ ☐ Disabled ☐ Kidney Disease

Name of insured	Name and address of insured's employer

Name and address of other insurance company	Policy number (other company)

Type of coverage	Has other insurance company paid?
☐ Single ☐ Family	☐ Yes (If yes, please submit a copy of their payment with these bills) ☐ No

Signature

Date signed (mm/dd/yyyy)

Please return form to:
BlueAdvantage Administrators of Arkansas
ATTN: Claims
P.O. Box 1460
Little Rock, Arkansas 72203

General information

You should submit your bills in a timely manner. To speed the processing of your claim, all bills must be itemized and attached to the claim form. ALL items on the claim form must be completed to insure proper payment.

Note: Cancelled checks, payment receipts, or balance forward bills are not acceptable

How to file a claim - Preparation of bills

A. Separate bills into the following groups:

1. Physician's Bills
2. Hospital Bills
3. Drug Bills or Prescriptions Drug Claim Forms
4. Durable Medical Equipment Bills
5. Ambulance Bills
6. Nurse's Bills
7. Physical Therapy & Speech Therapy Bills
8. Other Bills

B. Check the bills for the following information:

1. Physician's Bills - (Must be submitted on physician's office bill or a Blue Shield claim form.)
   a. Full name of patient
   b. Date(s) of service
   c. Full description of the type of procedures, medical services or supplies furnished for each date.
   d. Amount charged for each service
   e. Diagnosis
2. Hospital Bills
   a. Itemized statement from hospital, which must include diagnosis
3. Drug Bills
   a. Full name of patient
   b. Date(s) of purchase
   c. Prescription number
   d. Amount charged for each prescription
   e. Name of drugs and diagnosis
4. Durable Medical Equipment Bills - (Bill must include an invoice from the supplying firm) NOTE: On purchase of equipment, you must receive prior approval to be eligible for payment
   a. Full name of patient
   b. Date(s) of services
   c. Description of items
   d. Charge for each item
   e. Must have supporting statement from physician.
5. Ambulance Bills (Bills must be on ambulance firm's letterhead)
   a. Full name of patient
   b. Mileage of trip
   c. Charges per mile
   d. Points of departure and mileage
   e. Description of other services (i.e., oxygen, equipment, etc.)
   f. Charge for each service
   g. Total amount charged
6. Nurse's Bills - (Must have registration or license number of R.N. or L.P.N.)
   a. Full name of patient
   b. Professional status (i.e., R.N., or L.P.N., etc.) of each service
   c. Beginning and ending dates of the nursing service
   d. Time & number of hours worked
   e. Charge for the nursing service
   f. Nurse's name
7. Physical Therapy and Speech Therapy Bills (Must be on therapist's stationery)
   a. Full name of patient
   b. Date(s) of service
   c. Charge for each service
   d. Name of licensed therapist
   e. Must have appropriate evaluation forms submitted with bills
8. Other Bills - (Must include an invoice from the person or organization who provided the services)
   a. Name of person or organization who provided the services
   b. Full name of patient
   c. Date the service was provided
   d. Description of services
   e. Charge for each service

How to file a claim - Preparation of claim form

A. Patient Information (things to remember)

1. Enter FULL name of patient; patient's date of birth (month, day and year), and be sure to check the relationship to block.

B. Employee Information (things to remember)

1. You must enter FULL first and last name, middle initial.
2. You must enter the correct and complete Member Identification number before this claim can be processed.
3. You must enter the correct and complete address for mailing of payment.