State and School Employees' Health Insurance Plan
Self-Insured by the State of Mississippi

MEDICAL CLAIM FORM

• • • IMPORTANT: PLEASE READ THE INSTRUCTIONS ON THE BACK OF THIS FORM • • •
• • Your Physician does not need to sign this form • •
Please complete and sign a separate form for each patient

PATIENT INFORMATION

1. Patient's Name (No nicknames please)
   First MI Last

2. Name as Shown on I.D. Card
   First MI Last

3. Patient's Date of Birth
   ____ / ____ / ____
   Month Day Year

4. Identification Number as Shown on I.D. Card

5. Patient's Sex
   ☐ Male ☐ Female

6. Patient's Relationship to Employee
   ☐ Self ☐ Child ☐ Spouse ☐ Other

7. Current Mailing Address ☐ Check here if new address.
   Street City State Zip

   Current Telephone Numbers: Home ____ Office (optional) ____
   Area Code Area Code

   Payments and Explanation of Benefits will be sent to the most current address listed in our files.

OTHER HEALTH INSURANCE INFORMATION

8. Is patient covered under any other health insurance plan? ☐ Yes ☐ No
   If yes, complete the following: Name of Policyholder ____
   Last First Middle

   Name of Employer (if group coverage) ____

   Name and Address of Insuring Company ____
   Name

   Street

   Policy # ____ City State Zip

9. Is patient covered under Medicare Part A (hospital) or Medicare Part B (medical):
   Medicare Part A ☐ Yes ☐ No Effective Date ____ / ____ / ____
   Month Day Year
   Medicare Part B ☐ Yes ☐ No Effective Date ____ / ____ / ____
   Month Day Year
   Medicare Identification # ____

   Is employee still actively employed?
   ☐ Yes ☐ No
   If no, please enter effective date of retirement/ termination. ____ / ____ / ____
   Month Day Year

CONDITION AND TREATMENT

10. Was condition related to:
    Employment ☐ Auto Accident ☐ Other Accident/Injury ☐ Illness ☐

11. If Accident/Injury, give date.
    ____ / ____ / ____
    Month Day Year

12. Describe the nature of accident or illness and list symptoms.
    ____

AUTHORIZATION

I certify that the information I have given is accurate to the best of my knowledge and that I am claiming benefits only for the charges incurred by the patient identified above. I authorize the release of any medical information necessary to process this claim.

Signature ____ Date ____

WHEN SHOULD YOU USE THIS FORM?

This form is designed to help you file itemized medical bills for you or an enrolled family member. You should not submit this form if your healthcare provider has filed a claim for you. Retain your receipt for your records.

PLEASE REVIEW YOUR MEDICAL BILLS AND FILE CLAIMS AT LEAST ONCE A MONTH TO ENSURE THE TIMELY PROCESSING OF YOUR CLAIMS.

CLAIMS FILING INSTRUCTIONS

1 Gather All Your **Itemized Medical Bills**

2 Separate Your Bills For Each Family Member

3 Complete a Separate Claim Form For Each Family Member

- Attach **Itemized Medical Bills** for the patient named on the form. Each itemized bill must include the patient's name; the healthcare provider's name and address; the date of each service; descriptions and charge for each service.
- If you are covered under any other health insurance or under Medicare, you must attach a copy of the Explanation of Benefits indicating their payment.

DID YOU

**** USE A SEPARATE CLAIM FORM FOR EACH FAMILY MEMBER?

**** COMPLETE EACH SECTION OF THE CLAIM FORM ENTIRELY?

**** COPY YOUR IDENTIFICATION NUMBER DIRECTLY FROM YOUR ID CARD?

**** ATTACH THE ORIGINAL ITEMIZED BILL(S) FROM THE PROVIDER THAT DESCRIBES ALL SERVICES RENDERED AND INCLUDES DATES OF SERVICE AND CHARGES?

**** KEEP A COPY FOR YOUR RECORDS?

Please forward your completed form to:

Blue Cross & Blue Shield of Mississippi
P. O. Box 23071
Jackson, Mississippi 39225-3071

For further information or additional copies of this form, please contact our Customer Service Department. (1-800-709-7881)

Claims Administered by:

BlueCross BlueShield of Mississippi

Committed to a Healthier Mississippi.

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