SmartHealth

Member Self-reimbursement Claim Form

INSTRUCTIONS FOR FILING A MEDICAL CLAIM — Please read before completing the form on the next page.

1. This form is only needed to submit claims for services and supplies that are not submitted by your doctor or supplier (i.e., out-of-network doctors and hospitals). You must file your claim within one year from the date of service. You can submit your claim any time during the year. Payment of benefits are subject to all terms, conditions and limitations and exclusions of your health plan at the time of service. Completion of the form does not guarantee payment. ***The form must be filled out completely for processing.***
2. Use a separate claim form for each family member and each doctor or supplier.
3. All sections of the form must be filled out completely or your claim may be returned to you.
4. If your claim is a result of a motor vehicle accident, please provide a copy of the auto carrier's Explanation of Benefits or Letter of Exhaustion (if available).
5. If you have other insurance, please provide a copy of your ID card(s). Please send a copy of Explanation of Benefit statements from the other insurance company for the claim you are submitting (i.e., health or auto).
6. If your claim is for durable medical equipment (i.e., wheelchair, respirator, oxygen, etc.), you must submit the prescription along with a letter of medical necessity from the treating doctor.
7. Your original itemized bills and receipts must include:

   ⬜ Doctor or supplier name

   ⬜ Doctor or supplier address

   ⬜ Doctor or supplier Tax ID and NPI (National supplier Identifier) Number

   ⬜ Policy holder (member) name

   ⬜ Patient's full name

   ⬜ Type of service and procedure code

   ⬜ Date of service or purchase

   ⬜ Diagnosis Code

   ⬜ Modifier (when applicable)

   ⬜ Charge for each service

   Please note: The following are **not** acceptable documents: cash register receipts, canceled checks, money order receipts or personal lists. You must submit original bills or receipts from your doctor or supplier. Please keep a copy as the originals cannot be returned.
8. Please be sure to review your claim form and documents carefully to ensure we can process your claim accurately and quickly.

Email address for submissions

Please email your completed claim form and documents if applicable, to:

- shcr@abs-tpa.com
- Submission of labs: If you are submitting a claim for lab work the ordering physician's information is required (Name, Address, phone number, Tax ID and NPI).
- Allow 4-6 weeks for claims to be processed.
- Submit **international claims** to bcbsglobalcore.com or claims@bcbsglobalcore.com
- For questions please contact SmartHealth Customer Service at 888-492-6811

MEDICAL CLAIM FORM (To be completed by the member.)

- Complete **all** information or your form may be returned via email response.
- This form only needs to be completed if the doctor or supplier is not submitting on your behalf.
- Use a separate form for each family member and each doctor or supplier.
- Enclose **original** itemized bills. Keep a copy for your records.

See previous page for additional instructions.

Subscribers information (The **policy holder** name shown on the front of your ID card.)

Subscribers legal name (Last, First, Middle Initial)				Date of Birth - MM DD YYYY
Subscribers street address, check box if new address ☐	City		State	Zip Code
Member / contract number	Group number	Employer name (if applicable)		

Patient's information

Patient's legal name (Last, First, Middle Initial)	Date of Birth - MM DD YYYY
Patient's relationship to member: ☐ Self ☐ Spouse ☐ Child ☐ Other	**Patient's sex** ☐ Male ☐ Female

Patient's medical information (May be found on Itemized bill or receipt)

	Date of service / visit	Nature of visit / diagnosis code - ICD-10 code	Procedure code(s) (CPT)	Modifier (when applicable)	Doctor /Provider information
1	MM DD YYYY				Name: _____ Address: _____ TIN and NPI Number: _____ Phone Number: _____
2	MM DD YYYY				
3	MM DD YYYY				

Was the treatment the result of an accidental injury? ☐ Yes ☐ No Work Related? ☐ Yes ☐ No

Description of how accident or work related illness/injury occurred:

Please note: If this was an auto accident please include a copy of your auto carrier's Letter of Exhaustion. If this is work related, please provide a work related illness/injury report.

_____

_____

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Date of accident or beginning of illness:

Other coverage information (If yes, include a copy of your ID card from Medicare or other insurance company)

	Is the patient covered under any other insurance policy providing health care benefits or services? ⬜ Yes ⬜ No If Yes, complete section below.			
	Name on other policy:	Name of insurance:		Policy number:

Authorization and signature required

I certify the above is complete and correct and that I am claiming benefits only for charges incurred by the patient named above. Authorization is hereby given to any hospital, doctor, or other supplier which participated in any way in my care and treatment to release any medical information which they in their judgment deem necessary to the adjudication of this claim.

Please note: Any person who knowingly and with intent to injure, defraud, or deceive any insurance company files a statement of claim containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Signature of policy holder:_____ Date: _____

Authorization of payment to non-contracted doctors or suppliers (Signature required if payment is to be sent to the doctor(s) above.)

- Please allow 4-6 weeks for processing
- Please contact the customer service number located on the back of your insurance card to status claim