STATE HEALTH PLAN BENEFITS CLAIM FORM

South Carolina Public Employee Benefit Authority (PEBA)

You must attach copies of itemized bills (including diagnoses, date(s) service(s) received, procedure codes, provider name, and provider identification number(s)) 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 _____

MEDICARE INFORMATION

7

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 ____/ ____/ ____

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.

8

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.

CERTIFICATION OF MEMBER

9

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 _____

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 BIN – Benefits Identification Number (the ID number on your State Health Plan card);**

2. **Sign and date the form; and**

3. **Attach copies of itemized bills for services, including:**
   - **Diagnoses,**
   - **Date(s) service(s) received,**
   - **Procedure codes,**
   - **Provider name, and**
   - **Provider identification number(s).**