# PPO PROGRAM OUT-OF-NETWORK CLAIM FORM

Please Mail To: Claims Receipt Center
P.O. Box 211184
Eagan, MN 55121

(see reverse side for instructions)

<table>
<thead>
<tr>
<th>MEMBER/PATIENT</th>
<th>IDENTIFICATION NUMBER</th>
<th>GROUP NUMBER</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>MEMBER’S NAME (First, Middle, Last)</th>
<th>D NEW ADDRESS</th>
<th>CITY</th>
<th>STATE</th>
<th>ZIP CODE</th>
</tr>
</thead>
<tbody>
<tr>
<td>PATIENT’S NAME (First, Middle, Last)</td>
<td>RELATIONSHIP OF PATIENT TO MEMBER</td>
<td>SEX</td>
<td>BIRTH DATE</td>
<td></td>
</tr>
<tr>
<td>D SELF</td>
<td>D SPOUSE</td>
<td>D CHILD</td>
<td>D HANDICAPPED DEPENDENT</td>
<td>D OTHER</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>D NO</th>
<th>D YES</th>
<th>If yes, complete Part II:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>POLICYHOLDER’S NAME</th>
<th>BIRTH DATE</th>
<th>EMPLOYMENT STATUS OF POLICYHOLDER</th>
</tr>
</thead>
<tbody>
<tr>
<td>D ACTIVE</td>
<td>D DISABLED</td>
<td>D RETIRED</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>RELATIONSHIP OF POLICYHOLDER TO MEMBER</th>
<th>OTHER INSURANCE CARRIER’S NAME</th>
<th>IDENTIFICATION NO.</th>
<th>EFFECTIVE DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>D SELF</td>
<td>D SPOUSE</td>
<td>D CHILD</td>
<td>D OTHER</td>
</tr>
<tr>
<td>D NO</td>
<td>D YES</td>
<td>/</td>
<td>/</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>TYPE(S) OF COVERAGE</th>
<th>CONTRACT COVERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>D HOSPITALIZATION</td>
<td>D POLICYHOLDER ONLY</td>
</tr>
<tr>
<td>D MEDICAL-SURGICAL</td>
<td>D POLICYHOLDER AND SPOUSE</td>
</tr>
<tr>
<td>D DENTAL</td>
<td>D POLICYHOLDER AND CHILD(REN)</td>
</tr>
<tr>
<td>D VISION</td>
<td>D FAMILY</td>
</tr>
<tr>
<td>D DRUG</td>
<td>D OTHER</td>
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</tr>
<tr>
<td>D POLICYHOLDER AND CHILD(REN)</td>
</tr>
</tbody>
</table>

**Is the PATIENT entitled to benefits under MEDICARE HOSPITALIZATION Insurance (Part A)?**

D NO | D YES | EFFECTIVE DATE: / / | MEDICARE ID NUMBER:

**Does the PATIENT receive benefits under MEDICARE MEDICAL Insurance (Part B)?**

D NO | D YES | EFFECTIVE DATE: / / | MEDICARE ID NUMBER:

If you answered “YES” to either of the above, give employment status of the member listed in Part I:

D ACTIVE | D RETIRED | D DISABLED

**III.** DESCRIPTIVE CONDITIONS FOR WHICH YOU ARE REQUESTING BENEFITS AT THIS TIME:

**TYPE OF INJURY/ILLNESS**

**NAME OF DOCTOR TREATING INJURY/ILLNESS**

**DATE OF FIRST SYMPTOMS**

A. ________________________________________________

B. ________________________________________________

(Attach additional information, if necessary)

**PATIENT’S CONDITION**

**WERE SERVICES RELATED TO HOSPITALIZATION?**

D NO | D YES | If yes,

Give date of admission / / Give date of discharge / /

Hospital Name ___________________________ Admitting Physician ___________________________

**WERE EXPENSES DUE TO AN ACCIDENT?**

D NO | D YES | If yes, give type/place of accident:

Give date of accident / / D Auto D Work D Other (specify):

**IV.** I certify that the information provided on this claim form is correct and complete, and that I am claiming benefits only for charges actually incurred by the patient named. I authorize any hospital, physician or other provider who participated in the care and treatment of the patient to release to Independence Blue Cross all medical or other information requested for the processing of this claim. I hereby agree to reimburse Independence Blue Cross in full should this claim be incorrectly paid. Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

**MEMBER’S SIGNATURE**

**DATE**

**(AREA CODE) HOME PHONE**

**(AREA CODE) WORK PHONE**
INSTRUCTIONS:

Remember: This claim form should only be used when you see an Out-Of-Network provider who does not submit a claim for you.

1. Attach all itemized bills to this claim form. Bills should include the following information:
   - Name, address, and telephone number (on official bill head) of the PROVIDER rendering the service or supplying the item
   - PATIENT'S full name
   - DESCRIPTION of each service, or item supply
   - DATE AND AMOUNT CHARGED for each service, or supply
   - DIAGNOSIS

2. When you have already paid the out-of-network provider in full for the services, or supplies you are claiming, payment should be made to you (if you are our member). Please be sure to have the provider mark "PAID IN FULL" clearly on the bill.

3. Please be sure that a PHYSICIAN'S MEDICAL CERTIFICATION accompanies bills for:
   - Purchase or Rental of Medical Equipment

4. If submitting expenses for more than one family member, please use a SEPARATE claim form for each person.

5. Complete the entire claim form (have your physician complete the appropriate section, if necessary) and be sure to include the information requested above. This will avoid unnecessary delays in processing your claim. Keep a copy of this form and itemized bills for your records.

6. If you have QUESTIONS regarding the completion of this claim form, please contact Member Services at the telephone number shown on your ID card.

Out-of-network, non-participating providers may bill you for differences between the Plan allowance, which is the amount paid by Independence Blue Cross (IBC), and the provider's actual charge. This amount may be significant and it is not covered by IBC. Claims payments for out-of-network professional providers (physicians) are based on IBC's own fee schedule.
Language Assistance Services


Chinese: 注意：如果您讲中文，您可以得到免费的语言协助服务。致电 1-800-275-2583。

Korean: 안내사항: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-275-2583 번으로 전화하십시오。

Portuguese: ATENÇÃO: se você fala português, encontram-se disponíveis serviços gratuitos de assistência ao idioma. Ligue para 1-800-275-2583.

Gujarati: સૂચના: જે તમે ગુજરાતી બોલતા હો, તો મે ગુજરાતી ભાષા સહાય સેવાઓ તમારી માટે ઉપલબ્ધ છે. 1-800-275-2583 કોલ કરો.


Russian: ВНИМАНИЕ: Если вы говорите по-русски, то можете бесплатно воспользоваться услугами перевода. Тел.: 1-800-275-2583.

Polish UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-275-2583.

Italian: ATTENZIONE: Se lei parla italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-275-2583.

Arabic: بنحو، إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية متاحة لك بالمجان. اتصل برقم 275-2583.


Hindi: ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। कॉल करें 1-800-275-2583।


Japanese: 備考：母国語が日本語の方は、言語アシスタットサービス（無料）をご利用いただけます。1-800-(275-2583へ電話ください。

Persian (Farsi):توجه: اگر فارسی صحبت می کنید، خدمات ترجمه به صورت رایگان برای شما تهیه می شود. با شماره ۱-۸۰۰-۲۷۵-۲۵۸۳ تماس بگیرید.


Urdu: توجه درکار ہے: اگر آپ اردو زبان بولتے ہیں، تو آپ کے لئے مفت میں زبان معاون خدمات دستیاب ہیں۔ کال کریں 1-800-275-2583।

Mon-Khmer, Cambodian:សូមរង្វាន់កម្មវិធីសេវាតាមវិធីភាសានេះ។ បទពិសោធន៍ដែលមានប្រភេទកម្មវិធីសេវាតាមវិធីភាសានេះ អាចទទួលបានមកបាន 1-800-275-2583។
Discrimination is Against the Law

This Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. This Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

This Plan provides:

- Free aids and services to people with disabilities to communicate effectively with us, such as: qualified sign language interpreters, and written information in other formats (large print, audio, accessible electronic formats, other formats).
- Free language services to people whose primary language is not English, such as: qualified interpreters and information written in other languages.

If you need these services, contact our Civil Rights Coordinator. If you believe that This Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Civil Rights Coordinator. You can file a grievance in the following ways: In person or by mail: ATTN: Civil Rights Coordinator, 1901 Market Street, Philadelphia, PA 19103, By phone: 1-888-377-3933 (TTY: 711) By fax: 215-761-0245, By email: civilrightscoordinator@1901market.com. If you need help filing a grievance, our Civil Rights Coordinator is available to help you.