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DO NOT WRITE IN THIS BLOCK

Administered by: Blue Cross and Blue Shield of Florida, Inc.
P.O. Box 2896
532 Riverside Avenue
Jacksonville, FL 32232-0079

STATE OF FLORIDA
EMPLOYEES GROUP HEALTH SELF INSURANCE PLAN

EMPLOYEES CLAIM FORM

PART I **THIS PART MUST BE COMPLETELY FILLED IN**

PATIENT'S LAST NAME	FIRST NAME	MI	CONTRACT NUMBER	SEX	DATE OF BIRTH
			XJJ	☐M ☐F	mo. day yr.

RELATIONSHIP OF PATIENT TO EMPLOYEE

☐ Subscriber (SUB) ☐ Daughter (DAU)
☐ Spouse (SPO) ☐ Handicapped Dependent (HDP)
☐ Son (SON) ☐ Other (OTH)

WAS CONDITION RELATED TO:

A. Auto Accident? (Date:) Yes ☐ No ☐
B. Patient's Employment Yes ☐ No ☐

Complete this section for dependent children age nineteen and over:
1). Is the patient dependent on the subscriber for financial support? Yes ☐ No ☐

2). Does the patient reside in the subscriber's home or attend a licensed school, college or university? Yes ☐ No ☐

Employee's name and mailing address (include zip code)

Name and address (include zip code) of patient's employment (if any)

Date first treated for this illness(es). If more than one illness is indicated please list dates first treated for each illness.

Illness _____ Date _____
Illness _____ Date _____
Illness _____ Date _____

IS ANY INSURANCE OTHER THAN YOUR EMPLOYEES GROUP HEALTH SELF INSURANCE PLAN APPLICABLE TO THE EXPENSES AND SERVICES CONNECTED WITH THIS CLAIM? Yes ☐ No ☐ IF "YES", COMPLETE INFORMATION BELOW.

IS INSURANCE OBTAINED THROUGH EMPLOYER? Yes ☐ No ☐	POLICY NUMBER	EFFECTIVE DATE	Name and address of insurance company (include zip code)
NAME OF INSURED		TYPE COVERAGE Individual ☐ Family ☐	

Note: Do not list Supplemental Health Policies such as Cancer Policies, etc. Please refer to your Employee's Booklet for a definition of Group Plan.

HAS OTHER INSURANCE PAID ANY PART OF THE SERVICES PROVIDED? Yes ☐ No ☐ (If yes, attach copy of Summary of Benefits)

PLEASE INDICATE NATURE OF ILLNESS(ES) AND NAME OF PROVIDER(S)

NATURE OF ILLNESS	IF ACCIDENT, GIVE DATE	NAME OF PROVIDER (SIGNATURE NOT REQUIRED)

Employee's Certification: I certify that all information provided on this form and on the attached itemized statements are true and correct to the best of my knowledge.	Employee's Signature	Date	Telephone Number Area Code ( )

"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." Florida Statute, Section 817.234

PART II **COMPLETE FOR ASSIGNMENT OF PAYMENT ONLY**

ASSIGNMENT OF BENEFITS: I hereby assign my rights to payment for services covered under my contract to the following, but only to the extent of the amount of payment due for their services.

☐ PAY ME ☐ PAY PROVIDER

EMPLOYEE'S SIGNATURE _____

AFTER COMPLETING THIS FORM, SEND IT TO BLUE CROSS AND BLUE SHIELD OF FLORIDA, INC.
(See specific instructions on the reverse side of this form.)

HOW TO FILE A CLAIM

The hospital or physician will normally file a claim for services rendered making it unnecessary for you to submit a claim. However, if the hospital or physician does not file your claim, you must submit this claim form following the instructions outlined below.

Should you have claims on several family members, you must fill out a claim form for each family member.

To file a claim yourself, be sure to answer all questions on the claim form and attach all itemized bills. After completing and signing the form, send it (together with the itemized bills) to the Administrator using the special State Claims Post Office Box 2896. BY ANSWERING ALL QUESTIONS ON YOUR CLAIM FORM AND USING THE SPECIAL STATE CLAIMS POST OFFICE BOX 2896, THE ADMINISTRATOR WILL BE ABLE TO PROCESS YOUR CLAIM MUCH QUICKER AND AVOID THE DELAYS CAUSED BY OBTAINING ANY MISSING INFORMATION NECESSARY TO PROCESS YOUR CLAIM.

ITEMIZED BILLS FOR COVERED SERVICES OR SUPPLIES MUST BE ATTACHED AND THE ITEMIZED BILLS MUST CONTAIN:

(1) NAME OF THE PERSON OR ORGANIZATION PROVIDING THE SERVICES OR SUPPLIES
(2) NAME OF THE PATIENT RECEIVING THE SERVICES OR SUPPLIES
(3) EACH DATE THE SERVICES OR SUPPLIES WERE PROVIDED
(4) EACH CHARGE FOR THE SERVICES OR SUPPLIES
(5) DESCRIPTION OF THE SERVICES OR SUPPLIES

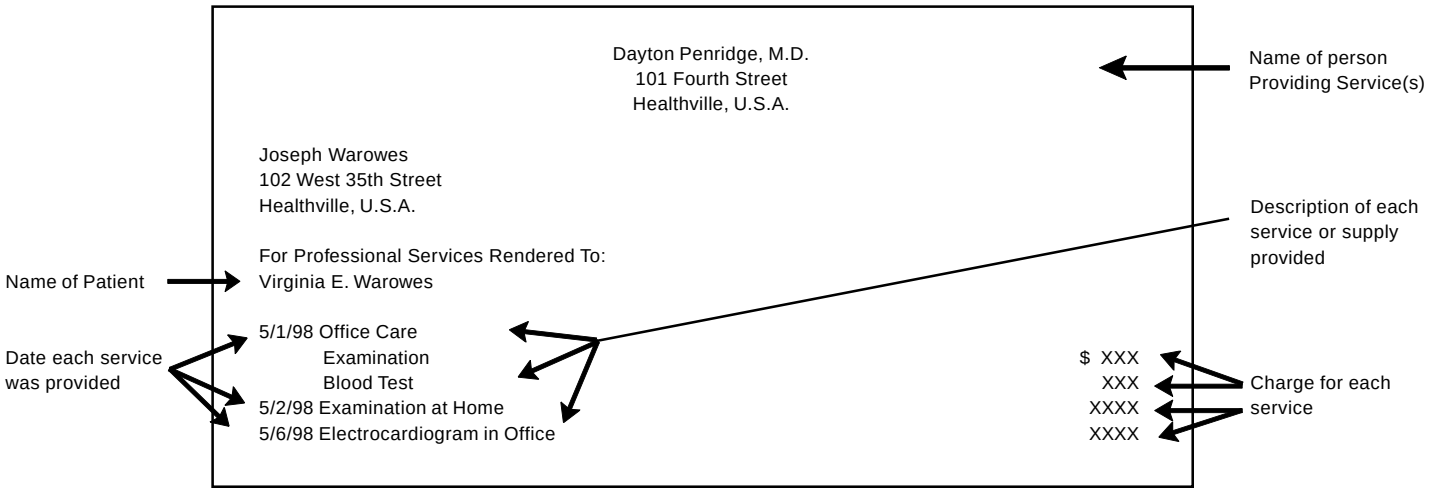
– IN ADDITION –

BILLS FOR SPECIAL NURSING SERVICE MUST SHOW THE PROFESSIONAL STATUS OF THE NURSE, SUCH AS R.N. (REGISTERED NURSE) AND REGISTRATION NUMBER. INCLUDE SHIFT(S) WORKED AND DATE(S).

BILLS FOR PRESCRIPTION DRUGS SHOULD BE FORWARDED TO THE PRESCRIPTION DRUG PROGRAM ADMINISTRATOR.

ITEMIZED BILLS CANNOT BE RETURNED

EXAMPLE OF ITEMIZED BILL:



This Completed Form, Together With The Itemized Bill And Supporting Material MUST Be Submitted To:

BLUE CROSS AND BLUE SHIELD OF FLORIDA, INC.
P.O. Box 2896
Jacksonville, FL 32232-0079