Non-network claim form
(see reverse side for instructions)

Personal CHOICE 65℠
A Blue Cross Medicare Advantage PPO Plan

1 Member/patient

Member name (first, middle, last)		Member identification number	Group number
Street address ❑ New address	City	State	ZIP
Gender: ❑ Male ❑ Female	Birth date _____|_____|_____ mm dd yyyy		

Does the PATIENT have additional health insurance benefits? ❑ No ❑ Yes (If yes, complete Part 2 below.)

2 Other insurance

Policyholder's name	Policyholder's birth date	Employment status of policyholder:
	_____|_____|_____ mm dd yyyy	❑ Active ❑ Disabled Effective date _____|_____|_____ mm dd yyyy ❑ Retired Effective date _____|_____|_____ mm dd yyyy

Other insurance carrier's name	Identification number	Insurance effective date
		_____|_____|_____ mm dd yyyy

3 Patient's condition

Describe the conditions for which you are requesting payment for out-of-network services rendered at this time:

Type of injury or illness	Name of doctor treating injury/illness	Date of first symptoms
A. _____	_____	_____|_____|_____ mm dd yyyy
B. _____	_____	_____|_____|_____ mm dd yyyy

Were expenses related to hospitalization? ❑ No ❑ Yes (If yes, please provide hospitalization information below.)

Date of admission _____\|_____\|_____ mm dd yyyy Date of discharge _____\|_____\|_____ mm dd yyyy

Hospital name _____ Admitting physician _____

Were expenses due to an accident? ❑ No ❑ Yes If yes, give type/place of accident: ❑ Work ❑ Auto

Date of accident _____\|_____\|_____ mm dd yyyy ❑ Other (specify) _____

4 Authorization

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.

Member signature	Date	Home phone	Work phone
_____		_____	_____

(over)

Instructions:

If your provider is a member of the Personal Choice 65 provider network, the provider will submit a claim form for you. This claim form should be submitted only when you use a non-network provider who does not submit claims for you.

- Please attach itemized bills to this claim form. These bills should include the following information:
  - Name, address, and telephone number of the provider (on the official bill from the provider rendering the service or supplying the item)
  - Patient's full name
  - Description of each service rendered or item supplied
  - Date and amount charged for each service rendered or item supplied
  - Diagnosis of ailment
- Please be sure that a physician's medical certification accompanies bills for purchase or rental of medical equipment. Your physician can provide you with this certification.
- Please complete the claim form carefully, and be sure to include the information requested above with your form. This will help to avoid unnecessary delays in processing your claim.
- If you have questions regarding the completion of this claim form, please contact Customer Service at 215-561-4877 (or 1-888-718-3333 outside Philadelphia), TTY/TDD 1-888-857-4816. Hours of operation: seven days a week, 8 a.m. to 8 p.m.

Please mail to:
Personal Choice 65 Claims
P.O. Box 69352
Harrisburg, PA 17106

Independence Blue Cross