Horizon Blue Cross Blue Shield of New Jersey

NJ State Health Benefits Program (SHBP)

NJ DIRECT Claim Form

THIS FORM CAN BE DOWNLOADED FROM OUR WEB SITE AT www.HorizonBlue.com/SHBP

Please Print This Form In Color (If Available).

SUBSCRIBER'S INFORMATION

1. LAST NAME | FIRST NAME | MI

2. DATE OF BIRTH (MM DD YYYY) | 3. SEX (M F) | 4. IDENTIFICATION NUMBER — Prefix: N J X | Number Portion: 3 H Z N

6. ADDRESS (No., Street) | CITY | STATE | ZIP CODE

7. TELEPHONE NUMBER (Include Area Code) | 8. EMPLOYER'S NAME

9. PLAN NAME: N J D I R E C T

10. DO YOU HAVE OTHER HEALTH COVERAGE? (No Yes) — IF YES, COMPLETE ITEMS 20 - 26

PATIENT'S INFORMATION (If Patient is the same as the Subscriber, please skip to #16)

11. LAST NAME | FIRST NAME | MI

12. DATE OF BIRTH (MM DD YYYY) | 13. SEX (M F) | 14. TELEPHONE NUMBER (Include Area Code)

15. ADDRESS (No., Street) | CITY | STATE | ZIP CODE

16. RELATIONSHIP TO INSURED (Self Spouse* Child Other) | 17. PATIENT'S STATUS (Single Married Other Employed)

18. IS PATIENT'S CONDITION RELATED TO:
a. EMPLOYMENT? (Current or Previous) (No Yes) | b. AUTO ACCIDENT? (No Yes) | PLACE (State) | C. OTHER ACCIDENT (No Yes)

19. DATE OF CURRENT ILLNESS (MM DD YYYY) — ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

OTHER HEALTH COVERAGE INFORMATION

20. LAST NAME OF SUBSCRIBER | FIRST NAME | MI

21. DATE OF BIRTH (MM DD YYYY) | 22. SEX (M F) | 23. IDENTIFICATION NUMBER

24. TELEPHONE NUMBER (Include Area Code) | 25. EMPLOYER'S NAME

26. HEALTH COVERAGE PLAN NAME OR PROGRAM NAME

AUTHORIZATION

27. I certify that the information provided is correct and complete, and that I am claiming benefits only for charges actually incurred by the patient named. I authorize any provider who participated in care and treatment to release to Horizon Blue Cross Blue Shield of New Jersey (Horizon BCBSNJ) all medical or other information requested for the processing of this claim. I agree that New Jersey State auditors, NJ State Health Benefits Program and Horizon BCBSNJ may see, or get a copy of any such medical records. This information is for the sole use of the New Jersey State Health Benefits Program and Horizon BCBSNJ to administer and analyze the health program. Unless a law requires it, information will not be given in an identifiable form to any other persons unless I agree to its release in writing. I agree to reimburse Horizon BCBSNJ should this claim be incorrectly paid.

SIGNATURE OF PATIENT (unless a minor) | DATE

*Spouse, Civil Union or Domestic Partner

SEE BACK OF THIS FORM FOR IMPORTANT INFORMATION

PLEASE READ THIS IMPORTANT INFORMATION

WHEN YOU ARE SUBMITTING EXPENSES FOR MORE THAN ONE FAMILY MEMBER, PLEASE USE A SEPARATE CLAIM FORM FOR EACH PERSON.
ITEMIZED BILLS FOR COVERED SERVICES OR SUPPLIES MUST BE ATTACHED TO THIS FORM AND INCLUDE THE FOLLOWING:

Check that each itemized bill is legible and contains ALL of the following information:

- ☑ NAME & ADDRESS of person or institution rendering the service or supplying the item
- ☑ PATIENT'S FULL NAME
- ☑ TYPE of service rendered/produced or item supplied
- ☑ DATE each service rendered or item supplied
- ☑ AMOUNT charged for each service rendered or item supplied
- ☑ DIAGNOSIS of ailment

BILLS MISSING ANY OF THIS INFORMATION MAY BE RETURNED TO YOU

Cash register receipts, cancelled checks, money order receipts, personal itemizations, and bills only noting a "balance due" are not acceptable.

COORDINATION OF BENEFITS?

If you or your covered dependent(s) are covered by another health insurance program, please provide the information requested in the Other Health Coverage Section. Example: Spouse covered by another insurance company or other Horizon Blue Cross Blue Shield of New Jersey coverage.

When submitting charges for services or supplies that have been partially paid or declined by other group health coverage, attach a copy of the Notice of Payment or Explanation of Benefits from the other health care insurer along with itemized bill(s).

MEDICARE?

If PATIENT is eligible for Medicare Benefits, be sure you include the Explanation of Medicare Benefits (EOMB) that was sent to patient explaining the charges paid or not paid by Medicare.

To process a claim for your NJ DIRECT secondary coverage, we need a copy of the EOMB. This EOMB should have been sent to you when Medicare processed your claim. If your EOMB has more than one page, send us copies of all pages. Please write your NJ DIRECT identification number clearly on the first page.

CLAIM FORM MAY BE RETURNED TO YOU IF THIS ADDITIONAL INFORMATION IS NOT SUPPLIED

HELPFUL HINTS

When you are submitting expenses for more than one family member, please use a separate claim form for each person.
It is suggested that you make copies for your own use before you submit the original bills.

Durable medical equipment? (Wheel chair, crutches, braces, oxygen, etc.) Your doctor's certification must be submitted indicating the expected length of time the equipment will be in use. If renting, please have your medical equipment supplier also indicate the purchase price of the equipment on the bill.

Foreign Claim? Bills for services incurred outside of the U.S. must include an English translation and the exchange rate at the time of services.

If you have any questions about how to submit your Claims, please call the Customer Service # 1-800-414-SHBP (7427).

WHERE TO SUBMIT YOUR CLAIM FORMS

Please mail completed claim form for:

MEDICAL CLAIMS TO:
Horizon Blue Cross Blue Shield of New Jersey
P.O. Box 820
Newark, NJ 07101-0820

MENTAL HEALTH/SUBSTANCE ABUSE CLAIMS TO:
Magellan/NJ DIRECT
PO Box 5172
Columbia, MD 21045-5172

FRAUD WARNING

ANY PERSON WHO KNOWINGLY FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE OR MISLEADING INFORMATION IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES

TO REPORT SUSPECTED FRAUD CALL 1-800-624-2048 AT HORIZON BLUE CROSS BLUE SHIELD OF NEW JERSEY