



# BlueAdvantage

## Administrators of Arkansas

An Independent Licensee of the Blue Cross and Blue Shield Association

P.O. Box 1460  
Little Rock, Arkansas 72203-1460

A SEPARATE CLAIM FORM MUST BE SUBMITTED FOR EACH PATIENT WHEN SENDING BILLS TO  
BlueAdvantage Administrators of Arkansas

|   |  |  |   |
|---|--|--|---|
| 1. GROUP NUMBER & NAME _____                          |  | 2. EMPLOYEES SOCIAL SECURITY NO. _____   |   |
| PATIENT'S INFORMATION                                 | 3. Patient's Last Name _____ Complete First Name _____ Initial _____   |  | 4. Date of Birth<br>Mo. ____ Day ____ Yr. ____  |
|   | 5. Sex<br><input type="checkbox"/> Male <input type="checkbox"/> Female  | 6. Patient's Relationship to Employee<br><input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other (Specify) _____ |   |
|   | 7. Diagnosis or Nature of Illness or Injury<br><br>_____<br><br>_____  |  |   |
|   | Date Illness Began: Mo. ____ Day ____ Yr. ____   |  |   |
|   | 8. Was this an accident?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   | 9. If yes, date of accident.<br>Mo. ____ Day ____ Yr. ____   | 10. Was this an automobile accident?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |
| EMPLOYEE INFORMATION                                  | 12. Is patient a full time student?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  | 13. If yes, what school? _____  |
|   | 14. Employee Last Name _____ First Name _____ Initial _____  |  | 15. ASSIGNMENT:<br>Payment for this claim should be made to:<br><br><input type="checkbox"/> Hospital <input type="checkbox"/> Doctor <input type="checkbox"/> Employee |
|   | 16. Employee Address<br><br>Street _____ City _____<br><br>State _____ Zip _____   |  |   |
|   | I hereby authorize any insurance company, prepayment organization, employer, hospital, or physician, to release all information with respect to myself or any of my dependents which may have a bearing on the benefits payable under this or any other plan providing benefits or services. I certify that the above information in support of this claim is true and correct.  |  |   |
|   | 17. Do you have other health insurance with a <u>group</u> or <u>government program</u> ?<br><input type="checkbox"/> Yes (Please complete section below) <input type="checkbox"/> Yes, Medicare A (Please submit your "Explanation of Medicare Benefits" with these bills.)<br><input type="checkbox"/> No <input type="checkbox"/> Yes, Medicare B<br>If Medicare, reason for coverage: <input type="checkbox"/> Over 65 <input type="checkbox"/> Disabled <input type="checkbox"/> Kidney Disease |  |   |
| 18. Name of Insured _____                             |  | 19. Name and Address of Insured's Employer _____   |   |
| 20. Name and address of other Insurance Company _____ |  |  | 21. Policy No. (other company) _____  |
| OTHER INSURANCE                                       | 22. Type of Coverage<br><input type="checkbox"/> Single<br><input type="checkbox"/> Family   |  | Has other Insurance Company paid?<br><input type="checkbox"/> Yes If yes, please submit a copy of their payment with these bills.<br><input type="checkbox"/> No        |

Date \_\_\_\_\_ Signature of Insured \_\_\_\_\_