Horizon Blue Cross Blue Shield of New Jersey

Star Unit PP-05Y
Horizon BCBSNJ
3 Penn Plaza East
Newark, NJ 07105-2200

FOR COPAY REIMBURSEMENTS ONLY, PLEASE CHECK THE FOLLOWING:

	POS	TOS	CPT	TAXID#
☐ MEDICAL	3	9	99199	7802COPAYREIMO
☐ PHARMACY	3	9	A9140	780200PHARMACY

Copayment Reimbursement Form

I. POLICYHOLDER

1. POLICYHOLDER'S NAME (Last, First, Middle Initial) (PLEASE TYPE OR PRINT)

2. POLICYHOLDER'S IDENTIFICATION NUMBER — PREFIX (If any) | NUMBER PORTION | SUFFIX (if any)

3. POLICYHOLDER'S ADDRESS (No., Street) CITY STATE ZIP CODE

4. TELEPHONE NUMBER (Include Area Code) ( )

5. POLICYHOLDER'S SOCIAL SECURITY NUMBER ___ ___ ___-___ ___-___ ___ ___ ___

6. POLICYHOLDER'S BIRTH DATE Month / Day / Year

6a. POLICYHOLDER'S SEX ☐ Male ☐ Female

7. EMPLOYER'S NAME

8. IF THIS IS A GROUP POLICY, INDICATE THE GROUP NUMBER

II. PATIENT

9. PATIENT'S NAME (Last, First, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:
a. EMPLOYMENT? (Current or Previous) ☐ YES ☐ NO
b. AUTO ACCIDENT ☐ YES ☐ NO STATE IN WHICH AUTO ACCIDENT OCCURRED: ________
c. OTHER ACCIDENT ☐ YES ☐ NO
d. DATE OF ACCIDENT Month / Day / Year
DATE OF YOUR FIRST SYMPTOM OF ILLNESS Or, if Pregnant, Date of your Last Menstrual Period Month / Day / Year

11. PATIENT'S BIRTH DATE Month / Day / Year

11a. PATIENT'S SEX ☐ Male ☐ Female

12. PATIENT STATUS ☐ Married ☐ Single ☐ Other

13. PATIENT'S RELATIONSHIP TO POLICYHOLDER ☐ Policy Holder ☐ Spouse ☐ Child ☐ Other

14. IS PATIENT ☐ Employed ☐ Full-Time Student ☐ Part-Time Student

III. COORDINATION OF BENEFITS

15. DOES THE PATIENT HAVE OTHER HEALTH INSURANCE? IF YES, COMPLETE ITEMS 15a-h
☐ YES ☐ NO

15a. IF MEDICARE, CHECK HERE AND ATTACH EOMB ☐

15b. OTHER POLICYHOLDER'S NAME (Last, First, Middle Initial)

15c. OTHER POLICYHOLDER'S BIRTH DATE Month / Day / Year

15d. OTHER POLICYHOLDER'S SEX ☐ Male ☐ Female

15e. OTHER POLICYHOLDER'S ADDRESS (No., Street) CITY STATE ZIP CODE

15f. OTHER INSURANCE PLAN'S NAME

15g. OTHER POLICYHOLDER'S IDENTIFICATION NUMBER AND GROUP NUMBER

15h. OTHER INSURANCE PLAN'S ADDRESS (No., Street) CITY STATE ZIP CODE

IV. AUTHORIZATION

16. 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 Horizon Blue Cross Blue Shield of New Jersey, all medical or other information requested for the processing of this claim form. I hereby agree to reimburse Horizon Blue Cross Blue Shield of New Jersey, in full should this claim be incorrectly paid.

AUTHORIZED SIGNATURE ________ DATE ________ (AREA CODE) HOME PHONE ________ (AREA CODE) WORK PHONE ________

WHEN YOU ARE SUBMITTING EXPENSES FOR MORE THAN ONE FAMILY MEMBER, PLEASE USE A SEPARATE CLAIM FORM FOR EACH PERSON.

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