



State Health Benefits Program (SHBP)



Horizon Blue Cross Blue Shield of New Jersey

Horizon Medicare Advantage NJ DIRECT (PPO)

THIS FORM CAN BE DOWNLOADED FROM OUR WEB SITE AT www.Horizonblue.com/SHBP-retiree

Please Print This Form In Color (If Available).

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AUTHORIZATION

20.1 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, 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 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

DATE

You may complete the required fields online and then save or print a

copy for submission. To save a completed copy to your computer, choose

File > Save As to rename the file and save the form with your information to your computer.

*Civil Union or Domestic Partner

PLEASE READ THIS IMPORTANT INFORMATION

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

- MAME & ADDRESS of person or institution rendering the service or supplying the item
- ☑ PATIENT'S FULL NAME
- TYPE of service rendered/produced or item supplied
- $\ensuremath{\boxdot}$ DATE each service rendered or item supplied
- $\ensuremath{\boxtimes}$ AMOUNT charged for each service rendered or item supplied
- DIAGNOSIS of ailment

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 are covered by another health insurance program, please provide the information requested in the Other Health Coverage Information Section.

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).

HELPFUL HINTS

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:

Horizon Blue Cross Blue Shield of New Jersey Horizon Behavioral Health P.O. Box 10191 Newark, NJ 07101-3189

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

