STATE HEALTH PLAN COMPREHENSIVE BENEFITS CLAIM FORM

South Carolina State Budget and Control Board, Employee Insurance Program

To file a claim, complete and sign this form. You must attach copies of itemized bills, including diagnoses, to receive proper payment for your claim.

1 Insured's Name _____ I.D.# **ZCS** _____

2 Patient's Name _____
First Middle Initial Last

3 The patient is: ☐ Female ☐ Male
The patient is the: ☐ Insured ☐ Insured's Spouse ☐ Insured's Child

4 Patient's Date of Birth _____
Month Day Year

5 Insured's Mailing Address _____
Street City State ZIP Code

6 Was the treatment required as a result of accidental injury? ☐ Yes ☐ No If yes, give date of accident _____

MEDICARE INFORMATION

7

Is the patient covered by Medicare? ☐ Yes ☐ No If yes, give date of Medicare No. _____

If yes, does the patient have Medicare Part A (Hospital Benefits)?

☐ Yes ☐ No Date coverage became effective _____/ ____/ ____

If yes, does the patient have Medicare Part B (Medical Surgical Benefits)?

☐ Yes ☐ No Date coverage became effective ____/ ____/ ____

Is patient entitled to Medicare because of ESRD? ☐ Yes ☐ No

Is patient actively working? ☐ Yes ☐ No

Is the patient disabled? ☐ Yes ☐ No

Is the patient retired? ☐ Yes ☐ No

If yes, give the date of retirement ____/ ____/ ____

OTHER GROUP INSURANCE COVERAGE

Is the patient covered under any other health benefit plan? ☐ Yes ☐ No

If yes, you must complete this section so your claims can be processed.

8

A. Name of other insurance company _____
Address of other insurance company _____

B. Name of insured under this policy (policyholder) _____
Relationship to patient _____
Insured's date of birth _____

C. Effective date of other insurance policy _____
Policy number of other insurance policy _____

Always attach your Explanation of Benefits or explanation of payment from your other plan.

CERTIFICATION OF MEMBER

9

I certify that the above information is correct and that the foregoing expenses were incurred for the above-named patient. I authorize any physician, nurse, hospital or other provider or supplier in possession of records or information concerning the patient to furnish such information to BlueCross BlueShield of South Carolina upon request.

INSURED'S SIGNATURE _____ DATE _____

Please see the other side of this form for mailing instructions.

Please send this form to:

BlueCross BlueShield of South Carolina
P.O. Box 100605
Columbia, SC 29260-0605

In Columbia: 803-736-1576
In S.C. and Nationwide: 800-868-2520

Before you mail your claim form, please remember to:

1. **Include the insured's State Health Plan Policy number;**
2. **Sign and date the form; and**
3. **Attach copies of itemized bills for services.**

Non-Discrimination Statement and Foreign Language Access

We do not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation or health status in our health plans, when we enroll members or provide benefits.

If you or someone you're assisting is disabled and needs interpretation assistance, help is available at the contact number posted on our website or listed in the materials included with this notice.

Free language interpretation support is available for those who cannot read or speak English by calling one of the appropriate numbers listed below.

If you think we have not provided these services or have discriminated in any way, you can file a grievance online at contact@hcrcompliance.com or by calling our Compliance area at 1-800-832-9686 or the U.S. Department of Health and Human Services, Office for Civil Rights at 1-800-368-1019 or 1-800-537-7697 (TDD).

Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de este plan de salud, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-844-396-0183. (Spanish)

如果您，或是您正在協助的對象，有關於本健康計畫方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話 [在此插入數字 1-844-396-0188。 (Chinese)

Nếu quý vị, hoặc là người mà quý vị đang giúp đỡ, có những câu hỏi quan tâm về chương trình sức khỏe này, quý vị sẽ được giúp đở với các thông tin bằng ngôn ngữ của quý vị miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-844-389-4838 (Vietnamese)

이 건보험에 관하여 궁금한 사항 혹은 질문이 있으시면 1-844-396-0187 로 연락주십시오. 귀하의 비용 부담없이 한국어로 도와드립니다. PC 명조 (Korean)

Kung ikaw, o ang iyong tinutulungan, ay may mga katanungan tungkol sa planong pangkalusugang ito, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika nang walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-844-389-4839 . (Tagalog)

Если у Вас или лица, которому вы помогаете, имеются вопросы по поводу Вашего плана медицинского обслуживания, то Вы имеете право на бесплатное получение помощи и информации на русском языке. Для разговора с переводчиком позвоните по телефону 1-844-389-4840. (Russian)

إن كان لديك أو لدى شخص تساعده أسئلة بخصوص خطة الصحة هذه، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة.للتحدث مع مترجم اتصل ب 1-844-396-0189 (Arabic)

Si ou menm oswa yon moun w ap ede gen kesyon konsènan plan sante sa a, se dwa w pou resevwa asistans ak enfòmasyon nan lang ou pale a, san ou pa gen pou peye pou sa. Pou pale avèk yon entèprèt, rele nan 1-844-398-6232. (French/Haitian Creole)

Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de ce plan médical, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 1-844-396-0190 . (French)

Jeśli Ty lub osoba, której pomagasz, macie pytania odnośnie planu ubezpieczenia zdrowotnego, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer 1-844-396-0186. (Polish)

Se você, ou alguém a quem você está ajudando, tem perguntas sobre este plano de saúde, você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para falar com um intérprete, ligue para 1-844-396-0182. (Portuguese)

Se tu o qualcuno che stai aiutando avete domande su questo piano sanitario, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare 1-844-396-0184. (Italian)

あなた、またはあなたがお世話をされている方が、この健康保険 についてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、1-844-396-0185 までお電話ください。 (Japanese)

Falls Sie oder jemand, dem Sie helfen, Fragen zu diesem Krankenversicherungsplan haben bzw. hat, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-844-396-0191 an. (German)

اگر شما یا فردی که به او کمک می کنید سؤالاتی در باره‌ی این برنامه‌ی بهداشتی داشته باشید، حق این را دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت کنید. برای صحبت کردن با مترجم، لطفاً با شماره‌ی 1-844-398-6233 تماس حاصل نمایید. (Persian-Farsi)
