

Qualified Health Care Expense Claim Form



Claims Mailing Address
 Anthem Blue Cross and Blue Shield
 QHE Mailpoint: IN0204-D441
 P.O. Box 166 Indianapolis, IN 46206-0166

Section A. PATIENT INFORMATION

Last name										First name										M.I.	
Street address (please include apt. no.)																					
City															State			ZIP Code			
Patient relationship to employee <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other												Sex <input type="checkbox"/> M <input type="checkbox"/> F		Date of birth (MM/DD/YYYY)							

Section B. EMPLOYEE INFORMATION

Employer name																									
Member ID no.						Daytime phone no.						Evening phone no.						Sex <input type="checkbox"/> M <input type="checkbox"/> F		Date of birth (MM/DD/YYYY)					
Last name										First name										M.I.					
Street address (please include apt. no.)																									
City															State			ZIP Code							

Section C. HEALTH CARE INFORMATION

Instructions:

- Below please provide detailed information about the services you are submitting for reimbursement. For a list of the services that qualify for QHE reimbursement see Section E of this claim form.
- Attach Explanation of Benefits (EOB) or Claims Recap showing amounts you are obligated to pay. If you do not have an EOB or Claim Recap, please provide an itemized bill or cash register receipt. Note: Itemized Bills contain the provider's name, the date of service, the amount charged, and a description of the service provided. Balance forward statements and cancelled checks are not considered itemized bills. Please include no more than 10 receipts or EOBs/Claim Recaps per form.
- Mail this form and supporting documentation to the address listed at the top of this form.
- Keep a copy of this form and attached supporting documentation for your records.

SERVICE DATE(S)	SERVICE TYPE (from Section E)	SERVICE CODE (from Section E)	PROVIDER/SUPPLIER NAME	AMOUNT
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
Indicate the total amount charged for the services/supplies noted: \$				

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Section D. AUTHORIZATION

I certify that either myself and/or my eligible dependents have incurred the expenses for which reimbursement is claimed and that I have not and will not deduct these expenses on my individual income tax return. I further certify this health care expense has not been reimbursed or is not reimbursable under any other employer-sponsored health care plan and that expenses have been paid. I authorize the release of any medical or other information necessary to process this claim.

All data requested on this form must be complete for claim consideration. We cannot consider any portion of this claim if this form is not signed. We also cannot consider any individual charges that do not have complete information.

Signature X	Print name	Date
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INSTRUCTIONS FOR SUBMITTING QUALIFIED HEALTHCARE EXPENSES ON THIS CLAIM FORM

When completing this form, you will need to attach an Explanation of Benefits (EOB) or Claims Recap, itemized receipts or cash register receipts and follow the instructions below for timely consideration of your charges.

SECTION A. PATIENT INFORMATION: This section pertains to the person receiving the services or supplies claimed on this form

- Patient's name - The full name of the patient.
- Patient's street address - The patient's home address, city, state and zip code.
- Date of birth - The month, day and year of the patient's birth.
- Gender - Specify if the patient is male or female.
- Patient relationship to employee - Specify whether the person receiving services or supplies on this claim form is the employee (self), or the employee's spouse, child or other dependent.

SECTION B. EMPLOYEE INFORMATION: This section pertains to the employee through whose employer your program is obtained

- Member ID number - The identification number found on your ID Card.
- Employee's name - The full name of the employee. Please complete the name as it appears on your ID Card.
- Employee's street address - The employee's home address, city, state and zip code.
- (New Address) - Be sure to notify your employer when you have an address change so they can update their files. We cannot update your employer's records.
- Date of birth - The month, day and year of the employee's birth.
- Gender - Specify if the employee is male or female.
- Employer's Name - The name of the employer or group.

SECTION C. HEALTH CARE INFORMATION: This section pertains to the employee through whose employer your program is obtained

- Date(s) of service - The month, day and year on which the service was received or the item purchased. If the charge is for multiple dates, list both the earliest date and the latest date for the charge.
- Amount - Amount the provider or supplier is charging you for the service.
- Service Type Received - The specific service(s) or supply(ies) received. Please refer to Section E on page three of this claim form for a list of services/supplies.
- Service Code - The specific service code. Please refer to Section E on page three of this claim form for a list of service codes.
- Provider/supplier - The provider or supplier's name.

SECTION D. AUTHORIZATION

REMEMBER TO ALWAYS SIGN YOUR CLAIM FORM as no portion of your claim can be considered without this. This is the most common reason for delay in consideration of items submitted.

SECTION E. DESCRIPTION OF SERVICES OR SUPPLIES

Use the list on Page 3 to identify the service(s) or supplies that apply to this claim form. Please specify no more than 10 types of service or supplies per claim form. An Explanation of Benefits, Claims Recap, itemized receipt or cash register receipt must be attached to this form. Service types not identified on Page 3 are ineligible for QHE reimbursement.

SERVICE TYPE	SERVICE CODE	SERVICE TYPE	SERVICE CODE
ACUPUNCTURE	QHE0A	LEAD PAINT REMOVAL	QHELK
ABORTION	QHEAB	MEDICAL (NONE OF THE OTHERS)	QHE0M
AIR CONDITIONER	QHEAC	MEDICAL INCAPACITATED	QHEMI
ARTIFICIAL LIMBS	QHEAL	METABOLISM TESTS	QHEMT
AMBULANCE	QHEAM	NEUROLOGIST	QHENE
ANESTHETIST	QHEAN	NURSING (INCLUDING BOARD AND MEALS)	QHENU
ARCH SUPPORTS	QHEAR	ORTHODONTIA	QHE0O
ABDOMINAL SUPPORTS	QHEAS	OBSTETRICIAN	QHEOB
ALCOHOLISM TREATMENT	QHEAT	OPTICIAN	QHEOC
AUTOETTE (FOR RELIEF OF SICKNESS)	QHEAU	OPHTHALMOLOGIST	QHEOL
BEHAVIORAL (MENTAL)	QHE0B	OPTOMETRIST	QHEOM
BIRTH CONTROL PILLS (PRESCRIPTION)	QHEBC	ORTHOPEDIST	QHEON
BLOOD TRANSFUSIONS	QHEBL	OPERATING ROOM COSTS	QHEOP
BRACES	QHEBR	ORAL SURGERY	QHEOR
BLOOD TESTS	QHEBT	ORTHOPEDIC SHOES	QHEOS
CARDIOGRAPHS	QHECA	ORGAN TRANSPLANT (INCL DONOR EXPNS)	QHEOT
CHRISTIAN SCIENCE PRACTITIONER	QHECS	OSTEOPATH	QHEOU
CHIROPRACTIC	QHE0C	OVER-THE-COUNTER MEDICATION	QHE0G
CONTRACEPTIVE DEVICES (PRESCRIBED)	QHECD	OXYGEN AND OXYGEN EQUIPMENT	QHEOX
CONVALESCENT HOME (MED TRTMT ONLY)	QHECH	PEDIATRICIAN	QHEPD
CONTACT LENSES	QHECL	PHARMACY PRESCRIPTION	QHE0P
CHIROPRACTOR	QHECP	PHYSICAL THERAPY	QHE0F
CORNEAL REFRACTIVE THERAPY	QHECR	PHYSICIAN	QHEPH
CRUTCHES	QHECT	PHYSIOTHERAPIST	QHEPT
DRUG ADDICTION THERAPY	QHEDA	PODIATRIST	QHEPO
DIAGNOSTIC FEES	QHEDF	PODIATRY	QHE0K
DIATHERMY	QHEDM	POSTNATAL TREATMENTS	QHEPM
DENTURES	QHEDN	PRACTICAL NURSE FOR MEDICAL SVCS	QHEPN
DERMATOLOGIST	QHEDR	PRENATAL CARE	QHEPC
DENTAL	QHE0T	PSYCHIATRIST	QHEPB
DENTAL TREATMENT	QHEDT	PSYCHOANALYST	QHEPA
DENTAL X-RAYS	QHEDX	PSYCHOLOGIST	QHEPL
PREVENTIVE CARE	QHE0E	PSYCHOTHERAPY	QHEPS
EYEGLASSES	QHEEG	REGISTERED NURSE	QHERN
ELASTIC HOSIERY (PRESCRIPTION)	QHEEH	RADIUM THERAPY	QHERT
FICA AND FUTA TAX PAID - MED SVCS	QHEFT	SPCL THERAPIES FOR AUTISTIC CHILDREN	QHESA
FLUORIDATION UNIT	QHEFU	SPINAL FLUID TEST	QHESF
GUIDE DOG	QHEGD	SPCL HOME FOR MENTALLY DISABLED DEP	QHESH
GUM TREATMENT	QHEGT	SPLINTS	QHESP
GYNECOLOGIST	QHEGY	SPCL SCHOOL COSTS FOR THE HANDICAPPED	QHESS
HEALTH INST FEES PAID (PRESCRIBED)	QHEFP	STERILIZATION	QHEST
HEALTH MANAGEMENT	QHEHM	SURGEON	QHESU
HEALING SERVICES	QHEHS	THERAPY EQUIPMENT	QHETE
HEARING	QHE0H	TRANSPORTATION EXPNS (FOR HLTHCARE)	QHETR
HEARING AIDS AND BATTERIES	QHEHA	PHONE/TV EQPT (FOR HARD-OF-HEARING)	QHETT
HOME BIRTHS	QHEHB	TUITION FOR SPCL SCHOOL (PRESCRIBED)	QHETU
HOSPITAL BILLS	QHEHO	ULTRA-VIOLET RAY TREATMENT	QHEUV
HYDROTHERAPY	QHEHY	VISION	QHE0V
INSULIN TREATMENT	QHEIT	VASECTOMY	QHEVA
LAMAZE OR BIRTHING CLASSES	QHELA	VACCINES	QHEVC
LAB TESTS	QHELB	VITAMINS (IF PRESCRIBED)	QHEVI
LASER EYE SURGERY	QHELE	WHEELCHAIR	QHEWC
LEGAL FEES	QHELF	WEIGHT LOSS PROGRAM	QHEWL
LODGING (FOR OUTPATIENT CARE)	QHELO	X-RAYS	QHEXR