

ATTACH  
RECEIPTS  
HERE



**Independence  
Blue Cross**

Benefits underwritten or administered by QCC Ins. Co.,  
a subsidiary of Independence Blue Cross – independent  
licensees of the Blue Cross and Blue Shield Association.

**PPO PROGRAM  
OUT-OF-NETWORK CLAIM FORM**

Please Mail To: **Claims Receipt Center  
P.O. Box 211184  
Eagan, MN 55121**

(see reverse side for instructions)

<b>I.</b>	MEMBER'S NAME ( <i>First, Middle, Last</i> )		IDENTIFICATION NUMBER		GROUP NUMBER	
	PRESENT ADDRESS STREET		CITY		STATE	ZIP CODE
	D NEW ADDRESS					
<b>MEMBER/PATIENT</b>	PATIENT'S NAME ( <i>First, Middle, Last</i> )		RELATIONSHIP OF PATIENT TO MEMBER		SEX	BIRTH DATE
			D SELF      D SPOUSE      D CHILD		D MALE	/ /
			D HANDICAPPED DEPENDENT      D OTHER		D FEMALE	/ /
<b>II.</b>	• Does the PATIENT have additional health insurance benefits?      D NO      D YES      If yes, complete Part II:					
	POLICYHOLDER'S NAME		BIRTH DATE		EMPLOYMENT STATUS OF POLICYHOLDER	
			/ /		DACTIVE      D DISABLED	
<b>OTHER INSURANCE</b>	RELATIONSHIP OF POLICYHOLDER TO MEMBER		OTHER INSURANCE CARRIER'S NAME		IDENTIFICATION NO.	EFFECTIVE DATE
	D SELF   D SPOUSE   D CHILD   D OTHER _____					/ /
	<b>TYPE(S) OF COVERAGE</b>					
<b>III.</b>	D HOSPITALIZATION      D MEDICAL-SURGICAL      D DENTAL      D VISION      D DRUG      D MAJOR MEDICAL					
	D OTHER _____					
	<b>CONTRACT COVERS</b>					
<b>PATIENT'S CONDITION</b>	D POLICYHOLDER ONLY      D POLICYHOLDER AND SPOUSE      D POLICYHOLDER AND CHILD(REN)      D FAMILY					
	• Is the PATIENT entitled to benefits under MEDICARE HOSPITALIZATION Insurance (Part A)?					
	D NO      D YES      EFFECTIVE DATE: / /      MEDICARE ID NUMBER _____					
<b>IV.</b>	• Does the PATIENT receive benefits under MEDICARE MEDICAL Insurance (Part B)?					
	D NO      D YES      EFFECTIVE DATE: / /      MEDICARE ID NUMBER _____					
	If you answered "YES" to either of the above, give employment status of the member listed in Part "I":					
<b>AUTHORIZATION</b>	D ACTIVE      D RETIRED      D DISABLED					
	• DESCRIBE CONDITIONS FOR WHICH YOU ARE REQUESTING BENEFITS AT THIS TIME:					
	<b>TYPE OF INJURY/ILLNESS</b>		<b>NAME OF DOCTOR TREATING INJURY/ILLNESS</b>		<b>DATE OF FIRST SYMPTOMS</b>	
<b>IV.</b>	A. _____		_____		_____	
	B. _____		_____		_____	
	(Attach additional information, if necessary)					
<b>AUTHORIZATION</b>	• WERE SERVICES RELATED TO HOSPITALIZATION?      D NO      D YES      If yes,					
	Give date of admission      /      /		Give date of discharge      /      /			
	Hospital Name _____		Admitting Physician _____			
<b>AUTHORIZATION</b>	• WERE EXPENSES DUE TO AN ACCIDENT?      D NO      D YES      If yes, give type/place of accident:					
	Give date of accident      /      /		D Auto      D Work      D Other (specify) _____			
	MEMBER'S SIGNATURE _____      DATE _____      (AREA CODE) HOME PHONE _____      (AREA CODE) WORK PHONE _____					

## INSTRUCTIONS:

**Remember: This claim form should only be used when you see an Out-Of-Network provider who does not submit a claim for you.**

1. Attach all itemized bills to this claim form. Bills should include the following information:
  - Name, address, and telephone number (on official bill head) of the PROVIDER rendering the service or supplying the item
  - PATIENT'S full name
  - DESCRIPTION of each service, or item supply
  - DATE AND AMOUNT CHARGED for each service, or supply
  - DIAGNOSIS
2. When you have already paid the out-of-network provider in full for the services, or supplies you are claiming, payment should be made to you (if you are our member). Please be sure to have the provider mark "PAID IN FULL" clearly on the bill.
3. Please be sure that a PHYSICIAN'S MEDICAL CERTIFICATION accompanies bills for:
  - Purchase or Rental of Medical Equipment
4. If submitting expenses for more than one family member, please use a SEPARATE claim form for each person.
5. Complete the entire claim form (have your physician complete the appropriate section, if necessary) and be sure to include the information requested above. This will avoid unnecessary delays in processing your claim. Keep a copy of this form and itemized bills for your records.
6. If you have QUESTIONS regarding the completion of this claim form, please contact Member Services at the telephone number shown on your ID card.

**Out-of-network, non-participating providers may bill you for differences between the Plan allowance, which is the amount paid by Independence Blue Cross (IBC), and the provider's actual charge. This amount may be significant and it is not covered by IBC. Claims payments for out-of-network professional providers (physicians) are based on IBC's own fee schedule.**

## Language Assistance Services

**Spanish:** ATENCIÓN: Si habla español, cuenta con servicios de asistencia en idiomas disponibles de forma gratuita para usted. Llame al 1-800-275-2583 (TTY: 711).

**Chinese:** 注意: 如果您讲中文, 您可以得到免费的语言协助服务。致电 1-800-275-2583。

**Korean:** 안내사항: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-275-2583 번으로 전화하십시오.

**Portuguese:** ATENÇÃO: se você fala português, encontram-se disponíveis serviços gratuitos de assistência ao idioma. Ligue para 1-800-275-2583.

**Gujarati:** सूचना: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. 1-800-275-2583 કોલ કરો.

**Vietnamese:** LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi sẽ cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho bạn. Hãy gọi 1-800-275-2583.

**Russian:** ВНИМАНИЕ: Если вы говорите по-русски, то можете бесплатно воспользоваться услугами перевода. Тел.: 1-800-275-2583.

**Polish:** UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-275-2583.

**Italian:** ATTENZIONE: Se lei parla italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-275-2583.

**Arabic:** ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية متاحة لك بالمجان. اتصل برقم 1-800-275-2583.

**French Creole:** ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-275-2583.

**Tagalog:** PAUNAWA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga serbisyo na tulong sa wika nang walang bayad. Tumawag sa 1-800-275-2583.

**French:** ATTENTION: Si vous parlez français, des services d'aide linguistique-vous sont proposés gratuitement. Appelez le 1-800-275-2583.

**Pennsylvania Dutch:** BASS UFF: Wann du Pennsylvania Deutsch schwetzsch, kannscht du Hilf griege in dei eegni Schprooch unni as es dich ennich eppes koschte zellt. Ruf die Nummer 1-800-275-2583.

**Hindi:** ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। कॉल करें 1-800-275-2583।

**German:** ACHTUNG: Wenn Sie Deutsch sprechen, können Sie kostenlos sprachliche Unterstützung anfordern. Wählen Sie 1-800-275-2583.

**Japanese:** 備考: 母国語が日本語の方は、言語アシスタンスサービス(無料)をご利用いただけます。1-800-275-2583へお電話ください。

### Persian (Farsi):

توجه: اگر فارسی صحبت می کنید، خدمات ترجمه به صورت رایگان برای شما فراهم می باشد. با شماره 1-800-275-2583 تماس بگیرید.

**Navajo:** Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'déé', t'áá jiiik'eh. Hódííłnih koji' 1-800-275-2583.

### Urdu:

توجه درکار ہے: اگر آپ اردو زبان بولتے ہیں، تو آپ کے لئے مفت میں زبان معاون خدمات دستیاب ہیں۔ کال کریں 1-800-275-2583

**Mon-Khmer, Cambodian:** សូមមេត្តាចាប់អារម្មណ៍: ប្រសិនបើអ្នកនិយាយភាសាមន-ខ្មែរ ឬភាសាខ្មែរ នោះ ជំនួយផ្នែកភាសានឹងមានផ្តល់ជូនដល់លោកអ្នកដោយឥតគិតថ្លៃ។ ទូរសព្ទទៅលេខ 1-800-275-2583។

## Discrimination is Against the Law

This Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. This Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

This Plan provides:

- Free aids and services to people with disabilities to communicate effectively with us, such as: qualified sign language interpreters, and written information in other formats (large print, audio, accessible electronic formats, other formats).
- Free language services to people whose primary language is not English, such as: qualified interpreters and information written in other languages.

If you need these services, contact our Civil Rights Coordinator. If you believe that This Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Civil Rights Coordinator. You can file a grievance in the following ways: In person or by mail: ATTN: Civil Rights Coordinator, 1901 Market Street, Philadelphia, PA 19103, By phone: 1-888-377-3933 (TTY: 711) By fax: 215-761-0245, By email: [civilrightscordinator@1901market.com](mailto:civilrightscordinator@1901market.com). If you need help filing a grievance, our Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf> or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.