BlueCross BlueShield of Illinois

Accident Claim Form

Return to Blue Cross Blue Shield of Illinois at:
Attention: Claims Department
P.O. Box 7070
Downers Grove, IL 60515

Phone Number: (800) 367-6401
Fax: (855) 645-8242

Employee Name _____ (Last) _____ (First) Social Security No. _____

Group Name _____

Group No. _____

INSTRUCTIONS

ACCIDENT INSURANCE

Your Accident Insurance benefit is a payment up to the specified amounts indicated in your Accident Insurance Certificate, if you experience a Covered Accidental Injury. If your claim is approved payment will be made to you.

WHO IS ELIGIBLE

To be eligible for this Benefit, you must meet the following conditions:

- Be insured under the Group Accident Insurance Policy at the time you sustained accidental injury for which benefits are being claimed.
- Provide written proof satisfactory to us from a medical professional that you have a Covered Accidental Injury or treatment related to that accident.

HOW TO APPLY

To apply, complete the claim packet in full. Each entry is important and must be completed to avoid delay in processing your claim. If an information block does not apply or if information is not available, please write "none" in the space provided.

Please review your certificate for specific benefits covered under this policy and provide medical documentation(s) from a healthcare provider or facility to support your claim.

Your claim packet consists of:

Section 1. Statement of Employer

To be completed by the Employer and returned to Blue Cross Blue Shield of Illinois (BCBSIL) along with Section 2.

Section 2. Employee Statement and Authorizations

- Employee and Claimant Information Statement requires your detailed completion and signature.
- Authorization for Release of Information allows us to contact your provider or medical facility for additional information if necessary and requires your signature.
- Optional Third Party Disclosure which allows us to discuss your claim with a third party.

Remember to sign and date each Statement. Your signature enables BCBSIL to obtain the information necessary to determine your eligibility for this benefit.

The completed claim form should be returned or faxed to the address at the top of this page.
The Employee is responsible for ensuring that all required portions of the claim form are completed and returned without expense to BCBSIL. Please keep a copy of this form and any attachments for your records. You may contact BCBSIL at 1-800-367-6401 with any questions or for assistance regarding this claim form packet.

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Group Name _____ Group No. _____

Part 1 - Statement of Employer — To be completed by Employer/Administrator

Group Number		Group Name		
Account/Division		Subsidiary Name		
Address — Street		City	State	Zip
Name and Title of Authorized Representative		Phone Number		
Fax Number		E-Mail Address		

Preferred communication: ☐ E-mail ☐ Phone ☐ Fax

Claimant Information

Name	Last	First	Middle	Relation to Employee/Member

Employee Information

Name	Last	First	Middle	

Social Security No.	Class	Date of Birth	Hire Date
Insurance Effective Date		If Terminated, Date of Termination	

(If any portion of premium is contributory please submit proof of payroll deduction)

Date of Last Premium Contribution:	Group	Member

I certify that I have read this document and the information is accurate and complete. I understand that any person who knowingly files a statement of claim containing any false or misleading information may be subject to criminal and civil penalties.

Signature of Authorized Employer/Plan Representative _____

Print Name _____ Date _____

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Part 2 - A. Employee Statement — To be completed by Employee

Employee Information

Name	Last	First	Middle		
Address:	Street	City	State	Zip	
Social Security No.	Date of Birth				

Claimant Information

☐ Same as Employee ☐ Child ☐ Spouse ☐ Domestic Partner

Name	Last	First	Middle		
Address:	Street	City	State	Zip	
Social Security No.	Date of Birth	Phone Number	E-Mail Address	Date of Accident	

Full Description of Accident:

Did the accident involve a motor vehicle: ☐ Yes ☐ No (if yes, please attach a copy of the police report)

Were you Driving: ☐ Yes ☐ No

Was the Accident Work Related: ☐ Yes ☐ No

Provider Information (Please list all providers you have received treatment from for this condition)

Name	Last	First	Middle	Phone	Fax	
Address:	Street	City	State	Zip		
Date Treated	Reason Treated	Specialty				

Hospital Information (Please list all facilities you have received treatment at for this condition)

Name		Phone	Fax		
Address:	Street	City	State	Zip	
Date Admitted	Date Discharged				

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Part 2 - B. AUTHORIZATION FOR RELEASE OF INFORMATION (We will require a separate authorization for release of psychotherapy notes.)

I authorize any physician, medical professional, pharmacist or other provider of health **care** services, hospital, clinic, other medical or medically related facility; coroner's office; insurance or reinsurance **company**; government agency; department of labor; law enforcement or public safety department; group policyholder; employer; or policy or benefit plan administrator to release **information** from the **records** of:

Claimant's Name: _____ (Last) _____ (First) _____ (Middle)

Claimant/Insured Information to be released:

- Data or records regarding medical history, treatment, prescriptions, consultations, autopsy (including medical reports; records, charts, notes (excluding psychotherapy notes), x-rays, films or correspondence, and any medical condition(s));
- Any information regarding insurance coverage; and
- Accident report or any official investigative reports (such as police, fire, FAA, OSHA, or toxicology report).
- Information to be released to:

  Blue Cross Blue Shield of Illinois
  P.O. Box 7070
  Downers Grove, IL 60515

- I understand the information obtained by use of this Authorization will be used by BCBSIL to evaluate my claim for Accident Insurance benefits. The Company will only release such information:
  - To its reinsurer, or other persons or organizations performing business or legal services in connection with my claim(s); or
  - As may be required by law; or
  - As I further authorize.
- I further understand that refusal to sign this Authorization may result in the denial of benefits.
- I understand the information used or disclosed may be subject to re-disclosure by the recipient and may no longer be protected by federal law.
- I understand that I may revoke this Authorization in writing at any time, except to the extent the Company has taken action in reliance on this Authorization. If written revocation is not received, this Authorization will be considered valid for a period of time not to exceed 24 months from the date of signature below. To initiate revocation of this Authorization, direct all correspondence to the Company at the above address.
- A photocopy of this Authorization is to be considered as valid as the original.
- I understand I am entitled to receive a copy of this signed Authorization.

Signature (Claimant or Representative) _____

Print Name _____ Date _____

If you are the legal representative of the Claimant we may ask for additional documentation.

Address: _____ (Street) _____ (City) _____ (State) _____ (Zip)

Phone No. _____

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Part 2 - C. OPTIONAL - DISCLOSING INFORMATION TO THIRD PARTIES

You are not required to sign this Optional Authorization. However, if you would like us to communicate with a family member, friend or other third party about your claim, we recommend completing the information below. Please sign and date the form as indicated and mail or fax it to the address or fax number indicated above.

Optional Authorization to Disclose Information to Third Parties

To assist in the evaluation or administration of my claim(s), I authorize The Company to share personal health and financial information relating to my claim with the family members, friends, and/or other third parties listed below:

My Spouse: _____ (Last) _____ (First) _____ (Middle) _____ (Phone)

Other Family Member: _____ (Last) _____ (First) _____ (Middle) _____ (Phone)

_____ (Relationship)

Other Person: _____ (Last) _____ (First) _____ (Middle) _____ (Phone)

_____ (Relationship)

I authorize The Company to leave messages about my claim on my voicemail / answering machine. ☐ Yes ☐ No

I understand that information about my claim may include information about my health and that such information about my health may be related to any disorder of the immune system including, but not limited to, HIV and AIDS; use of drugs and alcohol; and mental and physical history, condition, advice or treatment, but does not include psychotherapy notes.

I may revoke this authorization in writing at any time except to the extent The Company or the authorized recipient of my information has relied on it prior to receiving my notice of revocation. I may revoke this Authorization by sending written notice to the address above.

This authorization is valid for the shorter of two (2) years or the duration of my claim. I may request a copy of the Authorization and a copy shall be as valid as the original.

Signature (Insured/Claimant) _____

Print Name _____ Date _____

If you are the legal representative of the Claimant we may ask for additional documentation.

I signed on behalf of the claimant as _____ (indicate relationship)

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Instructions for requesting applicable benefits:

- Select the benefits that are being claimed for the covered person.
- Please attach all required documentation for the accidental injury.
- If a bill is required, please ask your provider for a UB04, HCFA 1500 or an itemized bill.
- Complete the Authorization to Release Information form.
- Refer to your group policy for details on the Benefits under your coverage. Benefits may vary by product and/or state.

Benefits being claimed ☐New ☐Continued (For Continued, provide Claim #:) _____

Benefit:	Date of Initial Diagnosis
Date of Initial Consultation	**ICD 9/10**
Benefit:	**Date of Initial Diagnosis**
Date of Initial Consultation	**ICD 9/10**

Benefit	**Documentation Required**
☐Emergency Room Treatment	Provide: Bill(s) and emergency room discharge summary showing emergency room services as outlined in the certificate.
☐Urgent Care Treatment	Provide: Bill(s) and the urgent care discharge summary showing urgent care services as outlined in the certificate.
☐Accident Physician Treatment	Provide: Bill(s) and the physician's office emergency treatment note(s) showing services as outlined in the certificate.
☐X-Ray Benefit	Provide: Bill(s) and medical record(s) supporting that an X-ray was required and performed as outlined in the certificate.
☐Accident Follow-Up Treatment	Provide: Bill(s) and medical record(s) supporting follow up treatment with the physician as outlined in the certificate.
☐Hospital Admission Benefit	Provide: Bill(s) showing room and board charges and the hospital discharge summary as outlined in the certificate.
☐Hospital Confinement Benefit	Provide: Bill(s) and hospital discharge summary as outlined in the certificate.

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Group No. _____

Benefit	Documentation Required
☐ Intensive Care Unit (ICU) Admission Benefit	Provide: Bill(s) showing intensive care room charges and the discharge summary as outlined in the certificate.
☐ Intensive Care Unit (ICU) Confinement Benefit	Provide: Bill(s) showing intensive care room charges and the discharge summary as outlined in the certificate.
☐ Dislocation Benefit	Provide: Bill(s), radiology report(s) and medical record(s) for the diagnosis and treatment. Joint Dislocated _____ ☐ Surgical Treatment ☐ Non-Surgical Treatment
☐ Burn Benefit	Provide: Bill(s) and medical record(s) documenting the burn as outlined in the certificate. ☐ 2nd Degree Burn ☐ 3rd Degree Burn
☐ Skin Graft Benefit	Provide: Bill(s) and operative report documenting the skin graft as outlined in the certificate.
☐ Eye Injury Benefit	Provide: Bill(s), treatment note(s) and/or operative report showing the eye surgical repair or removal of foreign body as outlined in the certificate.
☐ Laceration Benefit	Provide: Bill(s), treatment note(s) and/or operative report showing the eye surgical repair or removal of foreign body as outlined in the certificate.
☐ Fracture Benefit	Provide: Bill(s), radiology report(s) and medical record(s) to support the fracture and surgical or non-surgical treatment. Location of Fracture _____ ☐ Surgical Treatment ☐ Non-Surgical Treatment
☐ Concussion Benefit	Provide: Bill(s), medical record(s) and radiology report(s) to support the diagnosis of a concussion as outlined in the certificate.
☐ Dental Benefit	Provide: Bill(s) and medical record(s) showing the dental work treatment obtained as outlined in the certificate.

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Benefit	Documentation Required
☐ Coma Benefit	Provide: Bill(s) and hospital discharge summary supporting a coma with intubation for respiratory assisstance as outlined in the certificate.
☐ Paralysis Benefit	Provide: Bill(s) and hospital discharge summary supporting paralysis as outlined in the certificate. ☐ Quadriplegia ☐ Paraplegia ☐ Hemiplegia
☐ Surgical Procedure Benefit	Provide: Bill(s), medical record(s) and operative note(s) documenting surgical procedures services as outlined in the certificate. ☐ Outpatient Ambulatory Center
☐ Miscellaneous Surgical Procedure	Provide: Medical records documenting if the surgery was with ☐ General Anesthesia ☐ Conscious Sedation ☐ Outpatient Ambulatory Center
☐ Diagnostic Exams	Provide: Bill(s) and medical record(s) requiring the necessary diagnostic exams performed as outlined in the certificate.
☐ Epidural Pain Management	Provide: Bill(s) and medical record(s) documenting that an epidural was administered for pain management as outlined in the certificate.
☐ Physical Therapy Benefits	Provide: Bill(s) and medical record(s) documenting physical therapy treatment provided by a licensed Physical Therapist as outlined in the certificate.
☐ Rehabilitation Unit Benefit	Provide: Bill(s) and hospital discharge summary showing the rehabilitation transfer as outlined in the certificate.
☐ Appliance Benefit	Provide: Bill(s) and medical record(s) showing the physician order for the appliance as outlined in the certificate.
☐ Prosthesis Benefit	Provide: Bill(s) and medical record(s) requiring the prosthetic device(s) prescribed by a Physician as outlined in the certificate.

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Group Name _____

Group No. _____

Benefit	Documentation Required
☐ Blood/Plasma/Platelet Benefit	Provide: Bill(s) and medical record(s) showing the requirement for blood or plasma or platelet as outlined in the certificate.
☐ Ambulance Benefit	Provide: Bill(s) and the first responders' report documenting an ambulance transfer ☐ Air ☐ Ground
☐ Transportation Benefit	Provide: Bill(s) and the first responders' report supporting transportation to a treatment facility as outlined in the certificate.
☐ Lodging Benefit	Provide: Bill(s) for member companion lodging as outlined in the certificate.
☐ Accidental Death Benefit	Provide: The certified Death Certificate and the Police Report as outlined in the certificate. Does the insured have other Group coverages with BCBSIL: ☐ Life Insurance ☐ AD&D Insurance
☐ Accidental Death Common Carrier Benefit	Provide: The certified Death Certificate and the Police Report as outlined in the certificate. Does the insured have other Group coverages with BCBSIL: ☐ Life Insurance ☐ AD&D Insurance
☐ Accidental Dismemberment Benefit	Provide: The operative report and hospital discharge summary as outlined in the certificate. Does the insured have other Group coverages with BCBSIL: ☐ Life Insurance ☐ AD&D Insurance

Claimant Signature _____ Date _____

Employee Signature _____ Date _____

Print Name _____

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The laws of some states require us to furnish you with the following notice:

FOR APPLICATIONS AND CLAIMS:

Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

Colorado: It is unlawful to knowingly provide false, incomplete, or misleading material facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading material facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

District of Columbia: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Hawaii: For your protection, Hawaii law requires you be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Louisiana: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Maine & Washington: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Maryland: Any person who knowingly or willingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

New Mexico: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

Ohio: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Oklahoma: Any person who knowingly, with intent to injure, defraud or deceive any insurer, makes a claim for the proceeds of an insurance policy containing false, incomplete or misleading information is guilty of a felony.

Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Puerto Rico: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand dollars($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances be present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

Rhode Island: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Tennessee: It is a crime to knowingly provide false incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Virginia: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated the state law.

The laws of some states require us to furnish you with the following notice:

FOR CLAIMS ONLY:

Alaska: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

Arizona: For your protection, Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

Arkansas: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

California: For your protection California law requires the following to appear on this form. Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Delaware: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

Idaho: Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement or claim containing false, incomplete, or misleading information is guilty of a felony.

Indiana: A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

Minnesota: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

New Hampshire: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

Texas: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

FOR APPLICATIONS ONLY:

Massachusetts: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

New Jersey: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.