



PATIENT'S REQUEST FOR MEDICAL PAYMENT

IMPORTANT – SEE OTHER SIDE FOR INSTRUCTIONS

PLEASE TYPE OR PRINT INFORMATION

MEDICAL INSURANCE BENEFITS SOCIAL SECURITY ACT

NOTICE: Anyone who misrepresents or falsifies essential information requested by this form may upon conviction be subject to fine and imprisonment under Federal law. No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (20 CFR 422.510).

1	Name of Beneficiary from Health Insurance Card (Last) (First) (Middle)		SEND COMPLETED FORM TO: BlueCross BlueShield of South Carolina Medicare Advantage P.O. Box 100191 Columbia, SC 29202-3191 If you need help, call Customer Service at 1-855-204-2744
	2	Claim Number from Health Insurance Card	
3	Patient's Mailing Address (City, State, Zip Code) Check here if this is a new address <input type="checkbox"/>		3b Telephone Number (Include Area Code) (_ _ _) _ _ _ - _ _ _ _
	_____ (Street or P.O. Box – Include Apartment Number) _____ (City) (State) (Zip)		
4	Describe the illness or injury for which patient received treatment		4b Condition was related to: A. Patient's employment <input type="checkbox"/> Yes <input type="checkbox"/> No B. Accident <input type="checkbox"/> Auto <input type="checkbox"/> Other
			4c Was patient being treated with chronic dialysis or kidney transplant? <input type="checkbox"/> Yes <input type="checkbox"/> No
5	a. Are you employed and covered under an employee health plan? <input type="checkbox"/> Yes <input type="checkbox"/> No		Policy or Medical Assistance No. <input type="checkbox"/> Yes <input type="checkbox"/> No
	b. Is your spouse employed and are you covered under your spouse's employee health plan? <input type="checkbox"/> Yes <input type="checkbox"/> No c. If you have any medical coverage other than Medicare, such as private insurance, employment related insurance, State Agency (Medicaid), or the VA, complete: Name and Address of other insurance, State Agency (Medicaid), or VA office Policyholder's Name: _____		
Note: If you DO NOT want payment information on this claim released, put an (X) here <input type="checkbox"/>			
I AUTHORIZE ANY HOLDER OF MEDICAL OR OTHER INFORMATION ABOUT ME TO RELEASE TO THE SOCIAL SECURITY ADMINISTRATION AND CENTERS FOR MEDICARE & MEDICAID SERVICES OR ITS INTERMEDIARIES OR CARRIERS ANY INFORMATION NEEDED FOR THIS OR A RELATED MEDICARE CLAIM. I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL, AND REQUEST PAYMENT OF MEDICAL INSURANCE BENEFITS TO ME.			
6	Signature of Patient (If patient is unable to sign, see Block 6 on reverse)		6b Date signed
	_____ _____		

IMPORTANT
ATTACH ITEMIZED BILLS FROM YOUR DOCTOR(S) OR SUPPLIER(S) TO THE BACK OF THIS FORM