



How to Complete Your Out-of-Network Claim Form

Get Your Out-of-Network Claim Processed Faster

Did you recently see a provider out of your plan's network? Start by checking your benefits book to make sure you have out-of-network coverage*. If you submit an out-of-network claim form, it's important that Blue Cross® Blue Shield® of Arizona (AZ Blue) receives key pieces of information from you to process your claim.



As you complete the form, you'll want to have your member ID card and the itemized statement from your provider handy.

REMEMBER

Out-of-network claims must be submitted within one year of the date of service to be eligible for benefit.

* Out-of-network coverage is only applicable to Senior Preferred Medicare Supplement plans in emergency situations.



Your Personal Information and Insurance Policy Details

The key to getting your claim processed is providing accurate and complete information on your claim form. The top half of the claim form covers your personal information and your insurance coverage. Have your member ID card nearby.

 HEALTH INSURANCE CLAIM FORM APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12										CARRIER	
☐ PICA ☐ MEDICARE (Medicare#) ☐ MEDICAID (Medicaid#) ☐ TRICARE (ID# / DoD#) ☐ CHAMPVA (Member ID#) ☐ GROUP HEALTH PLAN (ID#) ☐ FECA (ID#) ☐ BLK LUNG (ID#) ☐ OTHER (ID#) ☐ PICA										1a. INSURED'S ID NUMBER (For Program in Item 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)			3. PATIENT'S BIRTH DATE MM : DD : YY M : F			4. INSURED'S NAME (Last Name, First Name, Middle Initial)					
5. PATIENT'S ADDRESS (No., Street)			6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐			7. INSURED'S ADDRESS (No., Street)					
CITY			STATE			CITY					
ZIP CODE			TELEPHONE (Include Area Code)			ZIP CODE					
TELEPHONE (Include Area Code)			8. RESERVED FOR NUCC USE			STATE					
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)			10. IS PATIENT'S CONDITION RELATED TO:			11. INSURED'S POLICY GROUP OR FECA NUMBER					
a. OTHER INSURED'S POLICY OR GROUP NUMBER			a. EMPLOYMENT? (Current or Previous) ☐ YES ☐ NO			a. INSURED'S DATE OF BIRTH MM : DD : YY M : F					
b. RESERVED FOR NUCC USE			b. AUTO ACCIDENT? ☐ YES ☐ NO			b. OTHER CLAIM ID (Designated by NUCC)					
c. RESERVED FOR NUCC USE			c. OTHER ACCIDENT? ☐ YES ☐ NO			c. INSURANCE PLAN NAME OR PROGRAM NAME					
d. INSURANCE PLAN NAME OR PROGRAM NAME			10d. CLAIM CODES (Designated by NUCC)			d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO If yes, complete items 9, 9a, and 9d.					
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.	
SIGNED _____ DATE _____										SIGNED _____	
14. DATE OF CURRENT ILLNESS, INJURY OR PREGNANCY (LMP) MM : DD : YY QUAL. _____			15. OTHER DATE MM : DD : YY QUAL. _____			16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM : DD : YY TO MM : DD : YY					

Insured's name (LINE 4)
ID number (LINE 1a)

 BlueCross BlueShield Arizona Not a member of the UnitedHealth Group of Companies	
Member Name: Sam Sample	Group No.: 0ABCX1
Member ID: XBS000000000	Card Print Date: 02/28/2022
Senior Preferred C	
AZDOI	

Group number (LINE 11)

The key items on the form that MUST be completed are:

- LINE 1a** The insured's ID number (Member ID on your ID card)
- LINE 2** The member's first and last name
- LINE 3** The member's birthdate
- LINE 4** The insured's name (Member Name on your ID card)
- LINE 6** The member's relationship to the insured
- LINE 11** The insured's policy group number (Group No. on your ID card)
- LINE 11a** The insured's birthdate
- LINE 13** The insured's signature

By signing this box, you agree to have payment sent directly from AZ Blue to the physician for service(s) provided. You may need to check with your provider to confirm they will "accept assignment" (accept payment directly from AZ Blue).

Your Provider and Diagnosis Information

The bottom half of the claim form requests information about your provider and your illness or injury. An itemized statement from your provider will be key to filling out this information, and a copy will need to be submitted to AZ Blue with your claim form. If you have a question about your statement and how to use it to fill out this part of the form, contact your provider.

14. DATE OF CURRENT ILLNESS, INJURY OR PREGNANCY (LMP) MM DD YY QUAL				15. OTHER DATE QUAL MM DD YY				16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY			
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE				17a. NPI				18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY			
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)				20. OUTSIDE LAB? ☐ YES ☐ NO				\$ CHARGES			
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.				22. RESUBMISSION CODE				ORIGINAL REF. NO.			
23. PRIOR AUTHORIZATION NUMBER											
24. A. DATE(S) OF SERVICE FROM MM DD YY TO MM DD YY				B. PLACE OF SERVICE				C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER			
E. DIAGNOSIS POINTER				F. \$ CHARGES				G. DAYS OR UNITS			
H. EPSTY FAMILY PLAN				I. ID. QUAL				J. RENDERING PROVIDER ID. #			
1								NPI			
2								NPI			
3								NPI			
4								NPI			
5								NPI			
6								NPI			
25. FEDERAL TAX I.D. NUMBER SSN EIN				26. PATIENT'S ACCOUNT NO.				27. ACCEPT ASSIGNMENT? ☐ YES ☐ NO			
28. TOTAL CHARGE \$				29. AMOUNT PAID \$				30. Rsvd for NUCC Use			
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)				32. SERVICE FACILITY LOCATION INFORMATION				33. BILLING PROVIDER INFO & PHONE # ()			
SIGNED DATE				a. b.				a. b.			

PHYSICIAN OR SUPPLIER INFORMATION

The key items on the form that **MUST** be completed are:

- LINE 21** Your diagnosis—this will be a code (found on the statement from your provider). If there were multiple diagnoses, there are multiple codes.
- LINE 24a** Date of service—This is the date(s) you saw your provider.
- LINE 24b** Place of service
- LINE 25** Your provider's tax ID number (found on the statement)
- LINE 28** Total charges (found on the statement)
- LINE 33** Add the name, address, and phone number for the provider that rendered the service(s).

That's it for this part of the form!



That's it! ✓

Before submitting your form, double check that you have filled in these key pieces of information.

To submit your claim, mail your completed form and corresponding provider statement to:

BLUE CROSS BLUE SHIELD OF ARIZONA
P.O. Box 2924
Phoenix, AZ 85062

If we have any questions about your form, we'll contact you. Once your claim has been processed, you will receive an Explanation of Benefits confirming the claim was processed and what out-of-network* benefit applies.

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.

*Out-of-Network coverage is only applicable to Senior Preferred Medicare Supplement plans in emergency situations.



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Notice of Nondiscrimination

Discrimination Is Against the Law

Blue Cross® Blue Shield® of Arizona (AZ Blue) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex (including sex characteristics, intersex traits, pregnancy or related conditions, sexual orientation, gender identity, and sex stereotypes). **AZ Blue** does not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

AZ Blue:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language assistance services to people whose primary language is not English, which may include:
 - Qualified interpreters
 - Information written in other languages

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, call 602-864-4884 for Spanish and 1-877-475-4799 for all other languages and other aids and services.

If you believe that **AZ Blue** 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:

Section 1557 Coordinator

P.O. Box 13466

Phoenix, AZ 85002-3466; Call 602-864-2288, TTY: 711

or email us at crc@azblue.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, **AZ Blue Section 1557 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, D.C. 20201
1-800-368-1019, 1-800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

This notice is available at AZ Blue's website: azblue.com/nondiscrimination-notice.



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Aviso de no discriminación

La discriminación es ilegal

Blue Cross® Blue Shield® of Arizona (AZ Blue) cumple con las leyes federales de derechos civiles vigentes y no discrimina por motivos de raza, color, origen nacional, edad, discapacidad ni sexo (de conformidad con el alcance de la discriminación sexual descrita en la Sección 92.101[a][2] del Título 45 del Código de Regulaciones Federales [CFR]) (o sexo, que incluye las características sexuales, como rasgos intersexuales, embarazo o condiciones relacionadas, orientación sexual, identidad de género y estereotipos sexuales). **AZ Blue** no excluye a las personas ni las trata de manera menos favorable por motivos de raza, color, nacionalidad, edad, discapacidad ni sexo.

AZ Blue:

- Brinda a las personas con discapacidades modificaciones razonables y ayudas y servicios auxiliares gratuitos y apropiados para comunicarse de manera eficaz con nosotros, tales como:
 - Intérpretes de lenguaje de señas calificados.
 - Información escrita en otros formatos (letra grande, audio, formatos electrónicos accesibles, otros formatos)
- Ofrece servicios gratuitos de asistencia lingüística a personas cuyo idioma principal no es el inglés, que pueden incluir:
 - Intérpretes calificados.
 - Información escrita en otros idiomas

Si necesita modificaciones razonables, ayudas y servicios auxiliares apropiados o servicios de asistencia lingüística, llame al 602-864-4884 para español y al 1-877-475-4799 para todos los demás idiomas y otras ayudas y servicios.

Si considera que **AZ Blue** no ha proporcionado estos servicios o ha discriminado de cualquier otra manera por motivos de raza, color, nacionalidad, edad, discapacidad o sexo, puede presentar una queja ante:

Section 1557 Coordinator

P.O. Box 13466

Phoenix, AZ 85002-3466; Call 602-864-2288, TTY: 711

o bien, envíenos un correo electrónico a crc@azblue.com

Puede presentar una queja en persona o por correo postal, fax o correo electrónico. Si necesita ayuda para presentar una queja, el **Coordinador de la Sección 1557 de AZ Blue** está disponible para ayudar.

También puede presentar un reclamo de derechos civiles ante la Oficina de Derechos Civiles del Departamento de Salud y Servicios Humanos de los EE. UU. de manera electrónica a través del Portal de reclamos de la Oficina de Derechos Civiles, disponible en <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, o por correo o teléfono a:

U.S. Department of Health and Human Services
200 Independence Avenue, SW Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 1-800-537-7697 (TDD)

Los formularios de reclamos están disponibles en <http://www.hhs.gov/ocr/office/file/index.html>. Este aviso está disponible en el sitio web de AZ Blue: azblue.com/nondiscrimination-notice.

Notice of Availability of Language Assistance Services and Auxiliary Aids and Services

English: Free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-800-232-2345, ext. 4122.

Spanish: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 1-800-232-2345, ext. 4122.

Navajo: Diné bee yáníítí'gogo, saad bee aná'awo' bee áka'anída'awo'ít'áá jik'eh ná hóló. Bee ahít hane'go bee nida'anishí t'áá ákodaat'éhígíí dóó bee áka'anída'wo'í áko bee baa hane'í bee hadadilyaa bich'í' ahoot'i'ígíí éí t'áá jik'eh hóló. Kohjì' 1-800-232-2345, ext. 4122.

Chinese Traditional: 如果您說[中文]，我們可以為您提供免費語言協助服務。也可以免費提供適當的輔助工具與服務，以無障礙格式提供資訊。請致電 1-800-232-2345, ext. 4122。

Tagalog: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1-800-232-2345, ext. 4122.

French: Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-800-232-2345, ext. 4122.

Vietnamese: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 1-800-232-2345, ext. 4122.

German: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzen zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 1-800-232-2345, ext. 4122.

Korean: [한국어]를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 1-800-232-2345, ext. 4122.

Russian: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-800-232-2345, ext. 4122.

Arabic:

تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم 1-800-232-2345, ext. 4122.

Hindi: यदि आप हिंदी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध होती हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएँ भी निःशुल्क उपलब्ध हैं। 1-800-232-2345, ext. 4122।

Farsi (Persian):

همچنین کمک‌ها و خدمات پشتیبانی مناسب برای ارائه اطلاعات صحبت می‌کنید، خدمات پشتیبانی زبانی رایگان در دسترس شما قرار دارد. فارسی اگر توجه: 1-800-232-2345, ext. 4122 با شماره در قالب‌های قابل دسترس، به‌طور رایگان موجود می‌باشند.

Thai: หมายเหตุ: หากคุณใช้ภาษาไทย เรามีบริการความช่วยเหลือด้านภาษาฟรี นอกจากนี้ ยังมีเครื่องมือและบริการช่วยเหลือเพื่อให้ข้อมูลในรูปแบบที่เข้าถึงได้โดยไม่เสียค่าใช้จ่าย โปรดโทรติดต่อ 1-800-232-2345, ext. 4122.

Japanese: 日本語を話される場合、無料の言語支援サービスをご利用いただけます。アクセシブル (誰もが利用できるよう配慮された) な形式で情報を提供するための適切な補助支援やサービスも無料でご利用いただけます。1-800-232-2345, ext. 4122。

Questions?

If you need additional help completing this form,
please call the number on the back of your ID card.



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