

Keystone Point of Service

TYPE OR PRINT

REMEMBER

TO AVOID DELAYS, BE SURE ITEM 9, EMPLOYEE'S SOCIAL SECURITY # IS PROVIDED

SECTION A	<p><i>I am choosing to receive covered healthcare services for myself or a dependent outside of the designated referral system. I understand that by using self-referred products, I will be subject to a deductible, coinsurance and other co-payments, as specified in the contract.</i></p>												
	SIGNED - EMPLOYEE OR SPOUSE X					DATE		THIS SECTION MUST BE SIGNED BEFORE A CLAIM MAY BE PROCESSED.					
INFORMATION WE NEED FROM YOU	1. PATIENT'S NAME (FIRST, M.I., LAST)					ID#							
	2. PATIENT'S ADDRESS (IF DIFFERENT FROM EMPLOYEE)		STREET			CITY		STATE		ZIP CODE		HOME TELEPHONE NO.	BUSINESS TELEPHONE NO.
	3. PATIENT'S DATE OF BIRTH (MONTH/DAY/YEAR)			4. PATIENT'S SEX		5. PATIENT'S RELATION TO EMPLOYEE							
				<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER							
	6. SUBSCRIBER'S NAME (FIRST, M.I., LAST)					ID#							
	7. SUBSCRIBER'S ADDRESS AND TELEPHONE NO.		STREET			CITY		STATE		ZIP CODE		HOME TELEPHONE NO.	BUSINESS TELEPHONE NO.
	8. WAS CONDITION RELATED TO:		A. PATIENT'S EMPLOYMENT		B. AN ACCIDENT		IF AN ACCIDENT	DATE	TIME	<input type="checkbox"/> AM <input type="checkbox"/> PM	DESCRIPTION (HOW AND WHERE)		
			<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO								
9. SUBSCRIBER'S SOCIAL SECURITY NUMBER					10. GROUP NAME (EMPLOYER'S COMPANY NAME)								
11. IS PATIENT COVERED BY ANY OTHER HEALTH PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO			IF YES	NAME OF POLICYHOLDER			NAME AND ADDRESS OF INSURANCE COMPANY						
				POLICY NUMBER									
12. IS PATIENT COVERED BY MEDICARE? <input type="checkbox"/> YES <input type="checkbox"/> NO			13. IS CHILD FULL-TIME STUDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO			I authorize the release of any information necessary to process this request.							
										14. SIGNED (PATIENT OR PARENT IF MINOR) X			
INFORMATION TO BE COMPLETED BY PHYSICIAN	15. NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED (IF OTHER THAN HOME OR OFFICE)										16. DATE FIRST CONSULTED YOU FOR THIS CONDITION		
	17. DIAGNOSIS, OR NATURE OF ILLNESS OR INJURY. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN BY REFERENCE TO #S 1,2,3 ETC. OR DX CODE												
	18. A. PLACE OF SERVICE	B. DATE OF SERVICE	C. FULLY DESCRIBE PROCEDURE, MEDICAL SERVICES, OR SUPPLIES FOR EACH DATE					D. DIAGNOSIS CODE OR UNITS	E. CHARGES				
			PROCEDURE CODE	MOD1	MOD2	EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES							
	19. YOUR PATIENT'S ACCOUNT NO.			20. PHYSICIAN OR SUPPLIER'S NAME, ADDRESS, ZIP CODE AND TELEPHONE NUMBER					22. TOTAL CHARGES				
	21. ENTER THE TAXPAYER ID NUMBER TO BE USED FOR 1099 REPORTING PURPOSES. YOU ARE REQUIRED BY LAW TO FURNISH YOUR TAXPAYER ID NUMBER.								23. AMOUNT PAID				
24. BALANCE DUE													
TAXPAYER ID NO.			25. SIGNATURE OF PHYSICIAN OR SUPPLIER					DATE					
26. SIGNED (PATIENT OR PARENT IF MINOR)													

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 material 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 persons to criminal and civil penalties. PROVIDERS: By signing this document, you swear or affirm that the services or materials for which claim is being made were necessary and were, in fact, furnished.

- For participants in ERISA, self-funded products, references to subscriber/member shall include participants, and payments for covered services will be made by Keystone Health Systems on behalf of the employer group.
- Independence Blue Cross offers products directly through its subsidiaries Keystone Health Plan East and QCC Ins. Co., and with Highmark Blue Shield. Independent Licensees of the Blue Cross and Blue Shield Association.

EMPLOYEE

1. EACH TIME YOU REQUEST BENEFITS, SIGN SECTION A AND COMPLETE SECTION B (ITEMS 1 - 14) ON THE REVERSE SIDE OF THIS FORM.

USE A SEPARATE BENEFIT REQUEST FORM FOR EACH MEMBER OF THE FAMILY.

2. ASK YOUR DOCTOR, HOSPITAL OR SUPPLIER TO COMPLETE SECTION C (THE PHYSICIAN OR SUPPLIER INFORMATION: ITEMS 15 - 25) OR ATTACH ITEMIZED BILLS.

ITEMIZED BILLS SHOULD INCLUDE:

- ✓ DOCTOR'S NAME & ADDRESS
- ✓ PATIENT'S NAME
- ✓ DATE OF SERVICE
- ✓ CONDITION BEING TREATED/DIAGNOSIS
- ✓ CHARGE FOR SERVICE
- ✓ TYPE OF SERVICE

SEND THIS REQUEST FOR BENEFITS TO
CLAIMS SERVICING CENTER
PO BOX 69353
HARRISBURG, PA 17106-9353

IF YOU HAVE ANY QUESTIONS, CALL
215-567-3550 OR
800-253-3854
OUTSIDE OF PHILADELPHIA

DOCTOR, HOSPITAL OR SUPPLIER

1. COMPLETE ITEMS 15 - 25 ON THE BENEFITS REQUEST FORM USING CURRENT CPT PROCEDURE AND ICD-9-CM DIAGNOSIS CODES.

2-DIGIT PLACE OF SERVICE CODES

(THE CURRENT 2-DIGIT PLACE OF SERVICE CODE MUST BE USED ON ALL CLAIM SUBMISSIONS)

11	OFFICE	51	INPATIENT PSYCHIATRIC FACILITY
12	HOME	52	PSYCHIATRIC FACILITY PARTIAL HOSPITALIZATION
21	INPATIENT HOSPITAL	53	COMMUNITY MENTAL HEALTH CENTER
22	OUTPATIENT HOSPITAL	54	INTERMEDIATE CARE FACILITY/MENTALLY RETARDED
23	EMERGENCY ROOM (HOSPITAL)	55	RESIDENTIAL SUBSTANCE ABUSE TREATMENT FACILITY
24	AMBULATORY SURGICAL CENTER (ASC)	56	PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY
25	BIRTHING CENTER	61	COMPREHENSIVE INPATIENT REHAB FACILITY
26	MILITARY TREATMENT FACILITY	62	COMPREHENSIVE OUTPATIENT REHAB FACILITY
31	SKILLED NURSING FACILITY (SNF)	65	END STAGE RENAL DISEASE TREATMENT CENTER
32	NURSING FACILITY	71	STATE OR LOCAL PUBLIC HEALTH CENTER
33	CUSTODIAL CARE FACILITY	72	RURAL HEALTH CLINIC
34	HOSPICE	81	INDEPENDENT LABORATORY
41	AMBULANCE (LAND)	99	OTHER UNLISTED FACILITY
42	AMBULANCE (AIR OR WATER)		