



**STATE OF MARYLAND EMPLOYEES HEALTH / VISION PLAN  
EMPLOYEE CLAIM FORM**



1.

Subscriber's Legal Name (Last, First, Middle Initial)		Patient's Legal Name (Last, First, Middle Initial)			
Membership Number		Patient's Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		Patient's Relationship to Subscriber 1 2 3 4 <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	
Subscriber's Address (Street) <input type="checkbox"/> Check box if NEW address		Patient's Date of Birth		Month	Date
City State Zip Code		NOTE: See reverse side for claim filing instructions including Routine Vision Care Services			
Telephone Number					
Group Number					

**IMPORTANT: ALL QUESTIONS MUST BE ANSWERED**

2.

List those illnesses for which you are submitting bills and date of first symptom.

_____	Date _____	_____	Date _____
_____	Date _____	_____	Date _____

3.

Was the treatment a result of an injury?  Yes  No      Was the treatment a result of an automobile accident?  Yes  No

Description of Accident \_\_\_\_\_

Date of Accident \_\_\_\_\_ Where Accident Occurred \_\_\_\_\_

4.

Was illness(es) or injury(ies) in any way work related?  Yes  No

5.

Does patient have Medicare?	Effective Date of Coverage	HEALTH INSURANCE CLAIM NUMBER
a. Medicare Part A (Hospital Insurance)? <input type="checkbox"/> Yes <input type="checkbox"/> No	____/____/____ Month Day Year	
b. Medicare Part B (Physician's Coverage)? <input type="checkbox"/> Yes <input type="checkbox"/> No	____/____/____ Month Day Year	

6.

In addition to coverage under this program, is patient covered under any other insurance providing health care benefits or services?  
 Yes  No      If "Yes", please complete:

a. Name of Policy Holder \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

b. Name of Insuring Co. \_\_\_\_\_

c. Policy or Certificate No. \_\_\_\_\_ d. Effective Date of Coverage \_\_\_\_/\_\_\_\_/\_\_\_\_  
Month Day Year

e. Check type of coverage:  Hospital  Surgical-Medical  Major Medical  Other (specify) \_\_\_\_\_

f. Check One: I have  Family  Husband and Wife  Individual  Parent and Child coverage with this carrier.

g. Name and Address of Policy Holder's Employer \_\_\_\_\_

7.

I certify the above is complete and correct and that I am claiming benefits only for charges incurred by the patient named above.

Authorization is hereby given to any hospital, physician, or other provider which participated in any way in my care and treatment to release to CareFirst BlueCross BlueShield any medical information which they in their judgement deem necessary to the adjudication of this claim.

**X** \_\_\_\_\_ SIGNATURE OF SUBSCRIBER      \_\_\_\_\_ DATE      Administrative Use Only  
Do not write in this space  
Provider# \_\_\_\_\_ Initials \_\_\_\_\_

**HAVE YOU ATTACHED YOUR ITEMIZED BILLS?**



**State of Maryland Operations Center**  
**P.O. Box 9885**  
**Baltimore, Maryland 21284-9855**

**STATE OF MARYLAND EMPLOYEES HEALTH / VISION PLAN EMPLOYEE CLAIM FORM**

This form is to be used only by members of the State Employees Health Plan to file **PPO, POS** and **Routine Vision Care** claims. While participating providers will bill CareFirst BlueCross BlueShield for services rendered, you may have claims to file yourself if you see non-participating providers.

- A copy of the bill on the provider's letterhead stationary

**IN ORDER FOR YOUR CLAIMS TO BE PROCESSED, THE FOLLOWING INFORMATION MUST BE SUBMITTED**

The bill must include:

- Provider's full name, degree, address, phone # and CareFirst BlueCross BlueShield provider number if available.
- Patient's full name
- Descriptions of each service or supply (**vision claims see outline below**)
- Date of which each service was provided
- The provider's diagnosis, or patient's chief complaint
- The amount charged by the provider for each service provided
- Bills in foreign language should be translated to English, foreign currency should be converted to American dollars
- Original bills should be submitted
- Keep a copy of your bills and claim for your records
- Provider's signature is required

- A completed claim form. Please be sure to accurately complete all sections of the claim form. Always use one claim form per patient.
- When another insurance carrier (including Medicare) is paying your claim first, please submit a copy of their payment statement with your claim. These statements are sometimes called "Explanation of Benefits," "Summary of Benefits," "Explanation of Medicare Benefits."

**BILLS FOR THE FOLLOWING SERVICES SHOULD INCLUDE THIS ADDITIONAL INFORMATION**

- Office Visits: ..... Type of visit (brief, intermediate, extended, etc.)
- Routine Vision:..... Date of visit, procedure codes for exam, lenses and frames. (See Chart Below)
- Private Duty Nursing: ..... Dates and shifts worked, amount charged for each shift, prescribing Doctor's name and degree, and registration # of nurse.
- Durable Medical Equipment: ..... Include the full purchase price of any rented equipment. A medical information form must be completed by your physician and submitted with the claim. Please contact our State of Maryland Operations Center to obtain these forms.  
(wheelchair, respirator, oxygen, etc.)
- X-rays:..... Type of x-ray (chest, legs, etc.)
- Blood Charges: ..... Include the number of pints received, charges for each, and the number of pints replaced by donors. Indicate whether bill is for whole blood, plasma or derivatives.
- General Anesthesia: ..... The length of time (in minutes) the patient was under general anesthesia must appear on the bill.
- Accidental Injury Claims: ..... Must indicate the date on which the accident occurred.

**Members of the Preferred Provider Option (PPO) and Point of Service (POS) – Note: Must have pre-authorization on file after the first 10 visits for outpatient physical therapy, occupational therapy and speech therapy. See your benefit booklet, section: Managed Care Authorization Program for more information.**

**ELIGIBLE VISION SERVICES**

Description of Service	Procedure Code	Service Date	Charge
<input type="checkbox"/> EXAM	92002-92004 92012-92014		
<input type="checkbox"/> FRAME-DISPLAY _____ YES _____ NO	V2020		
<input type="checkbox"/> SINGLE VISION	V2100-V2114		
<input type="checkbox"/> BIFOCAL, SINGLE	V2200-V2214		
<input type="checkbox"/> BIFOCAL, DOUBLE	V2799		
<input type="checkbox"/> TRIFOCAL	V2300-V2314		
<input type="checkbox"/> APHAKIC (LENTICULAR)	V2116-V2217		
<input type="checkbox"/> CONTACT LENSES (NOT MEDICALLY REQUIRED)	V2500-V2522		
<input type="checkbox"/> CONTACT LENSES (MEDICALLY REQUIRED)	V2799		
DATE OF CATARACT SURGERY: _____ VISUAL ACUITY BEFORE: _____ AFTER: _____ LENSES. WOULD GLASSES CORRECT VISUAL ACUITY TO AT LEAST 20/70 IN THE BETTER EYE: _____ YES _____ NO <b>NOTE: PROCEDURE CODE MAY VARY ACCORDING TO SERVICE PROVIDED.</b>			

Preferred Provider Option (PPO) Local: 410-581-3601 Toll-Free 1-800-225-0131,  
 Point of Service (POS) Local: 410-581-0021 Toll-Free 1-800-203-2763.  
 HMO Plan Local: 410-654-8675 Toll-Free 1-800-445-6036  
 Access our website at [www.carefirst.com/statemd](http://www.carefirst.com/statemd)