TRIPLE-S SALUD
BlueCross BlueShield of Puerto Rico

SUBSCRIBER MEDICAL CLAIM FORM

A. PATIENT INFORMATION

1. NAME (LAST NAME, SURNAME, NAME, INITIAL)

7. PATIENT'S SUBSCRIBER ID (CONTRACT) NUMBER (INCLUDE ALPHA PREFIX)
Z U __

2. ADDRESS LINE 1 (Use if different than subscriber's address)

8. PRIMARY TELEPHONE NUMBER

9. FAX NUMBER

3. ADDRESS LINE 2

10. ALTERNATE TELEPHONE NUMBER

11. GROUP NUMBER (See ID Card)

4. CITY | 5. STATE | 6, ZIP CODE

12. GROUP NAME

13.

B. OTHER INSURANCE INFORMATION (COORDINATION OF BENEFITS)

14. DOES PATIENT HAVE OTHER HEALTH INSURANCE PLAN? ☐ NO ☐ YES
If yes, fill information below.

15. IS PATIENT MEDICARE ELIGIBLE? ☐ NO ☐ YES
If yes, include Medicare plan type and HICN (Claim Number) below:

16. NAME OF OTHER INSURANCE COMPANY OR PLAN

17. MEDICARE CLAIM NUMBER (HICN) ☐ Part A ☐ Part B

18.POLICY/ CONTRACT NUMBER

19. GROUP NUMBER

20. OTHER INSURANCE TELEPHONE NUMBER

21. OTHER INSURANCE FAX NUMBER

When submitting charges for covered services or supplies that have been partially paid or declined by other group health insurance, attach a copy of the Notice of Payment or Explanation of Benefits from the other insurance carrier along with the itemized bills. For Medicare charges, include the Medicare Explanation of Benefits (MEOB).

22. OTHER INSURANCE ADDRESS

23. FOR *TRIPLE- S SALUD* USE ONLY

C. ACCIDENT / INJURY INFORMATION (Complete only if the claim was due to an accidental injury)

24. PATIENT CONDITION RELATED TO:
☐ ACCIDENT AT WORK ☐ AUTO ACCIDENT ☐ OTHER ACCIDENT, describe:

25. DATE OF ACCIDENT (MONTH/DAY/YEAR) / /

26. TIME OF ACCIDENT AM / PM

27. DID ANOTHER PERSON CAUSE THIS ACCIDENT? ☐ NO ☐ YES

28. CAN THE OTHER PERSON BE CONSIDERED LEGALLY RESPONSIBLE FOR THIS ACCIDENT? ☐ NO ☐ YES

D. PATIENT AUTHORIZATION

29. I certify that the information provided on this claim form is correct and complete, and that I am claiming benefits only for charges actually incurred by the patient named. I authorize any hospital, physician, or other health care institutions or providers who participated in the care treatment of the patient to release to *TRIPLE-S SALUD* and its authorized representatives, all medical or other information requested for the purpose of evaluating and processing of this benefit claim.

PATIENT, SUBSCRIBER OR AUTHORIZED REPRESENTATIVE SIGNATURE — DATE

E. INFORMATION ON MEDICAL SERVICES OR SUPPLIES

30. PROVIDER/SUPPLIER NAME

31. PROVIDER/SUPPLIER ID (**National Provider Identifier -NPI**) ☐ EIN ☐ NPI

32. PROVIDER LICENCE NUMBER

33. PROVIDER/SUPPLIER ADDRESS

34. PROVIDER SPECIALTY

35. PATIENT ACCOUNT OR RECORD NUMBER

36. SERVICES RENDERED IN:
Puerto Rico ☐ U.S. ☐ Outside of P.R. or U.S.
Indicate where:

37. PROVIDER TELEPHONE NUMBER

38. DIAGNOSIS — ICD

39. PLAN PREVIOUS AUTHORIZATION NUMBER

40	DATE OF SERVICE		TYPE	PLACE OF SERVICE	SERVICE DESCRIPTION	PROCEDURE CODE	MOD	DAYS / UNITS	*Bar Code (COVID HOME TEST)*	REASON FOR PURCHASE OF COVID HOME TEST (see back)	TOTAL PAID
	FROM MM/DD/YYYY	TO MM/DD/YYYY									
1											
2											
3											
4											
5											
6											

SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS

SIGNED — DATE

PROVIDER OR SUPPLIER STAMP

***TRIPLE-S SALUD* USE ONLY**

SMCF-001E Rev. 02-09I

SEE BACK OF THIS FORM FOR IMPORTANT INFORMATION

PLEASE READ THIS IMPORTANT INFORMATION

FOR THE PATIENT / SUBSCRIBER SUBMITTING THE CLAIM

1. Use this form for all your covered medical, surgical, hospital services, procedures or supplies claims.
2. Complete all applicable fields, date and sign the form.
3. If you are submitting expenses for more than one family member, please *use a separate claim form for each person*.
4. Use a separate claim form for services rendered or items supplied in different plan years.
5. Please include and attach original itemized bills and Explanation of Benefits for all claimed services or supplies.
6. Each itemized bill must be legible and MUST include the following information:
   - Name and address (in letterhead) of provider or institution rendering service or supplying the item.
   - Provider's Name and Address.
   - National Provider Identifier (NPI) and one of the following numbers: Tax Id or State License.
   - Patient's Full Name
   - Type of service rendered or item supplied (office visit, chest x-ray, etc.)
   - Date of each service rendered or item supplied
   - Amount charged for each service rendered or item supplied
   - Diagnosis of ailment (the medical condition for which the patient was treated).
   - **Include your *TRIPLE-S SALUD* subscriber identification (contract) number clearly on each bill or document.**
7. In case of COVID 19 home tests you must include:
   - The bar code of the test (you will find the same on the test box)
   - Identify the reason for purchasing COVID 19 home tests. Reason of purchase: 1- Employment, 2- Exposition and 3- Symptoms

NOTE: Stand alone cash register receipts, cancelled checks, money order receipts, personal itemizations, and bills only noting "Balance Due" are NOT acceptable.

ADDITIONAL INFORMATION REQUIRED FOR CERTAIN CLAIMS Bills for the following covered services must also include:

1. **Ambulance Service**: A statement of medical necessity from the attending doctor which indicates why ambulance transport was required and an itemized bill from the ambulance provider showing the amount paid for transport, date and miles traveled.
2. **Private Duty Nurse**: Copy of the plan's previous approval (pre-authorization), the type of nurse (RN or LPN), license number, the shift and hours worked and a statement of medical necessity for the prescribing doctor.
3. **Durable Medical Equipment** (wheelchair, oxygen tank, etc.): Copy of the plan's previous approval (pre-authorization), a statement of medical necessity from the prescribing doctor which indicates how long the equipment will be used and a statement from the equipment supplier showing both the rental and purchase price.
4. **Surgical Assistance** (when surgical procedure required assistance of another surgeon): Copy of the Surgical Report and include full name of surgical assistant.
5. **Prescription Drug** benefit claims should be filed using the Prescription Drug Claim Form.
6. **Anesthesia:** Anesthesiologists invoice or payment receipt must include service minutes or units.

BILLS MISSING ANY OF THE THIS INFORMATION WILL DELAY PROCESSING AND MAY BE RETURNED TO YOU.

COORDINATION OF BENEFITS INFORMATION

If you or any of your dependents is covered by another health insurance program, please provide the information requested in section 3 OTHER INSURANCE INFORMATION.

When submitting charges for covered services or supplies that have been partially paid or declined by other group health insurance, attach a copy of the Notice of Payment or Explanation of Benefits from the other insurance carrier along with the itemized bills.

MEDICARE

If PATIENT is eligible for Medicare benefits, make sure to include the Explanation of Medicare Benefits (EOMB) that was sent to the patient explaining the charges paid or not paid by Medicare. If your EOMB has multiple pages, send us copies of all pages.

INSURANCE FRAUD WARNING

INSURANCE FRAUD IS A CRIME WHICH CAN RESULT, AMONG OTHERS, IN LOSS OF YOUR HEALTH INSURANCE COVERAGE, CIVIL AND CRIMINAL PENALTIES. WHICH, IF CONVICTED, CAN RESULT IN FINES AND INCARCERATION.

Act 18 of January 8, 2004 states: Any person who, knowingly and with the intent to commit fraud, provides false information in an insurance application, or provides, helps in providing or assists in the transmittal of a fraudulent claim for payment of loss, or any related benefit, or files multiple claims for the same loss or benefit, will incur in a felony, whereupon, if convicted, will be sanctioned with aN economic fine of no less than five thousand ($5,000) but no more than ten thousand ($10,000) per violation, or incarceration for a mandatory term of three (3) years, or both. In case of aggravating circumstances, this term could be extended to a maximum of five (5) years; and in case of mitigating circumstances, it could be reduced to two (2) years.

Mail your completed claim form and documents to:

TRIPLE-S SALUD
Reimbursements Department
PO BOX 363628
San Juan, PR 00936-3628

www.ssspr.com