### **HEALTH BENEFITS CLAIM FORM**



PLEASE COMPLETE A SEPARATE CLAIM FORM FOR EACH FAMILY MEMBER. PLEASE COMPLETE A SEPARATE CLAIM FORM FOR EACH PROVIDER. (SEE REVERSE SIDE FOR FILING INFORMATION)
PLEASE COMPLETE EACH NUMBERED ITEM—FAILURETO DO SO MAY RESULT IN DELAYS IN PROCESSING YOUR CLAIM

PLEASE TYPE OR PRINT		*THIS FORM CAN ALSO	BE USED FOR FILING CLAIM	IS FOR CAREFIRST BLUE	ECHOICE OPT-OUT <i>PLUS</i> .	
1. IDENTIFICATION NUMBER	2. GROUP NUMBER OR ENROLLMENT CODE	3. PATIENT'S NAME (FIRST	, MIDDLE INITIAL, LAST)			
4. PATIENT'S DATE OF BIRTH MO DAY YEAR	5. PATIENT'S SEX		ATIENT'S RELATIONSHIP TO SUBSCRIBER:			
MU DAY YEAR	FEMALE MALE	SELF SPOUSE SPOUSE	CHILD ☐ OTHER ☐ EX	(PLAIN:		
7. SUBSCRIBER'S NAME (FIRST, MIDDLE IN	TIAL, LAST)	·	DAYTIMETELEPHONE NUM		DE)	
			( ) –			
9. SUBSCRIBER'S ADDRESS (STREET, CITY,	STATE, ZIP CODE) CHECK IF NEW ADDRESS					
10. IS PATIENT COVERED UNDER OTHER HE	EALTH INSURANCE? NO 🔲 YES 🔲 IFYES, NAM	E OF OTHER INSURANCE CO	MPANY			
NAME OF POLICY HOLDER	POLICY OR IDENTIFICAT	POLICY OR IDENTIFICATION NUMBER				
IS PATIENT COVERED UNDER MEDICARE?	IF THE SUBSCRIBER IS MARRIED, IS THE SPOUSE EMPLOYED? NO $\square$ YES $\square$ IF YES, GIVETHE NAME OF THE SPOUSE'S EMPLOYER					
IFYES, PART A PART B MEDICARE N						
IS PATIENT ACTIVELY EMPLOYED? NO						
11. WAS PATIENT'S CONDITION DUE TO:  AUTO ACCIDENT? NO U YES U ANY OTHER ACCIDENTAL INJURY? NO U YES WORK RELATED ACCIDENT OR CONDITION? NO U YES  MO DAY YEAR  MO DAY YEAR						
	IF AN ACCIDENT, GIVE THE DATE  MO DAY YEAR	OF THE ACCIDENT			AULT? NO YES	
IF MEDICAL EMERGENCY GIVE DATE SYMP				S, ATTACH A STATEMEN CCIDENTAL INJURY ON 1		
12.WAS PATIENT HOSPITALIZED? NO DAY  ADMISSION DATE	YES IFYES, COMPLETE THE FOLLOWING YEAR MO DAY YE DISCHARGE	AR NAME & ADDRESS O				
	CHED? NO YES IFYES, GIVE NAME OF PHY	ADMITTING PHYSICIA				
	51E5. 110 <b>—</b> 120 <b>—</b> 11 120, and 14 14 11		REQUESTED TO OBTAIN A S	ECOND SURGICAL OPIN	IION? NO U YES U	
					NDED? NO 🔲 YES 🔲	
	NO 🔲 YES 🔲 IFYES, WHAT IS THE DATE OF TH	IE LAST MENSTRUAL PERIOI	D? MO DAY	YEAR		
15. STATE THE DIAGNOSIS, SYMPTOMS, ILI HAS PATIENT HAD THESE SYMPTOMS/0	.NESS OR INJURY FOR THE EXPENSES CLAIMED		GIVE DATE SYMPT	OM(S) FIRST STARTED	MO DAY YEAR	
BEFORE? NO YES IFYES, WHI		MO DAY YEAR  GIVE DATE PHYSICIAN FIRST SEEN				
16.LIST BELOW ONLY THOSE CHARGES BE	NG CLAIMED AND ATTACH ORIGINAL ITEMIZED BI	1		I	1	
NAME(S) OF PROVIDER(S)	DESCRIPTION(S) OF SERVICE(S)	DIAGNOSIS (IF MORETHAN ONI		TO DATE	CHARGE	
A.			MO DAY YEAR	MO DAY YEAR	•	
В.			/ /	/ /	\$	
C.			//	/ /	\$ .	
D.			///	/ /		
				TOTAL	\$ .	
18. THIS CLAIM FORM MU IF NOT, IT WILL BE RE		AUTHORI (SEE REV	IZATION FOR ASS	SIGNMENT OF	BENEFITS	
		I, the under	signed, authorize Care		ueShield to make	
is correct and that the foregoing ex named patient. I authorize any phys	es and certify that the above information penses were incurred for the above sician, nurse, hospital or other providers nation concerning the patient to furnish		r benefits due herein t	0		
such information to CareFirst Blue(		Name of Provid	er r Social Security Number			
	MO DAY YEA	AR	•			
Subscriber Signature		Name of Provid	er			
	sents a false or fraudulent claim for payment of a	Provider's Tax o	r Social Security Number		MO DAY YEAR	
loss or benefit or who knowingly or willfull insurance is guilty of a crime and may be s	y presents false information in an application for ubject to fines and confinement in prison.	Subscriber Sign	nature		Date /	

## **INSTRUCTIONS**

# THIS FORM IS TO BE USED TO SUBMIT A CLAIM FOR SERVICES UNDER YOUR HEALTH PLAN. TO AVOID HAVING YOUR CLAIM RETURNED:

- ✓ PREPARE A **SEPARATE CLAIM FORM** FOR EACH FAMILY MEMBER.
- ✓ COMPLETE ALL OF THE INFORMATION REQUESTED IN ITEMS 1 THRU 18.
- ✓ IFYOU PREFER THAT BENEFITS BE PAID TO THE PROVIDER OF SERVICE BE SURE

  TO COMPLETE THE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS ON THE FRONT.

  CAREFIRST BLUECROSS BLUESHIELD RESERVES THE RIGHT TO MAKE PAYMENT DIRECTLY

  TO THE SUBSCRIBER AND TO REFUSE TO HONOR THE ASSIGNMENT OF ANY CLAIM TO ANY

  PERSON OR PARTY.

### EACH PROVIDER'S ORIGINAL ITEMIZED BILL MUST BE ATTACHED AND CONTAIN:

- ✓ THE LETTERHEAD INDICATING THE NAME AND ADDRESS OF THE PERSON OR ORGANIZATION PROVIDING THE SERVICE
- ✓ THE NAME OF THE PATIENT RECEIVING THE SERVICE
- ✓ THE DATE FOR EACH INDIVIDUAL SERVICE (A RANGE OF DATES CANNOT BE ACCEPTED)
- ✓ THE CHARGE FOR EACH INDIVIDUAL SERVICE
- ✓ A DESCRIPTION OF EACH SERVICE
- ✓ PROVIDER'S TAX IDENTIFICATION NUMBER OR NPI
- ✓ PHYSICIAN OR PHARMACIST'S SIGNATURE

ON EACH BILL, PLEASE CROSS OUT ANY CHARGES THAT WERE INCLUDED ON A PREVIOUS CLAIM. PERSONAL ITEMIZATIONS, CASH REGISTER RECEIPTS, CREDIT CARD RECEIPTS AND CANCELLED CHECKS ARE NOT ACCEPTABLE. ITEMIZED BILLS CANNOT BE RETURNED.

### IN ADDITION TO THE ABOVE REQUIREMENTS. THE FOLLOWING INFORMATION WILL BE NEEDED:

ACCIDENTAL INJURY - STATEMENTS MUST CONTAIN DETAILS AS TO WHEN, WHERE AND THE MANNER IN WHICH THE INJURY OCCURRED, AS WELL AS THE NAME AND ADDRESS OF THE PARTY AT FAULT.

**PRESCRIPTION DRUGS** - BILLS MUST INCLUDE THE PRESCRIPTION NUMBER, THE NAME OF THE DRUG AND THE NAME OF THE PHYSICIAN PRESCRIBING THE MEDICATION.

PRIVATE DUTY NURSING - BILLS MUST INCLUDE THE SHIFT WORKED, THE CHARGE PER HOUR, THE NUMBER OF HOURS WORKED, THE NURSE'S PROFESSIONAL STATUS, PROFESSIONAL LICENSE NUMBER AND FAMILY RELATIONSHIP TO THE PATIENT, IF ANY. A STATEMENT FROM THE ATTENDING PHYSICIAN MUST ACCOMPANY THE CLAIM. THE STATEMENT SHOULD EXPLAIN THE MEDICAL NECESSITY OF THE SERVICE AND THE AUTHORIZATION FOR IT.

PROSTHETIC APPLIANCES AND THE RENTAL OR PURCHASE OF DURABLE MEDICAL EQUIPMENT - A STATEMENT FROM THE ATTENDING PHYSICIAN MUST ACCOMPANY THE CLAIM. THE STATEMENT SHOULD EXPLAIN THE MEDICAL NECESSITY OF THE EQUIPMENT AND THE PHYSICIAN'S AUTHORIZATION FOR IT.

**PSYCHOTHERAPY** - BILLS MUST INCLUDE THE LENGTH OF THE SESSION, THE TYPE OF SESSION AND THE PROVIDER'S PROFESSIONAL STATUS. IF THE PROVIDER IS OTHER THAN A MEDICAL DOCTOR, THE PROVIDER'S PROFESSIONAL LICENSE NUMBER MUST ALSO BE GIVEN.

FOR PATIENTS COVERED BY ANOTHER INSURANCE CARRIER OR MEDICARE - IF THE PATIENT IS CLAIMING BENEFITS FOR ANY CHARGES THAT ARE ELIGIBLE FOR BENEFITS UNDER ANY OTHER HEALTH INSURANCE POLICY OR MEDICARE PART A AND/OR PART B, THE EXPLANATION OF BENEFITS FORM FURNISHED BY THE OTHER CARRIER PERTAINING TO THESE CHARGES MUST BE INCLUDED WITH THE ITEMIZED BILLS. A CLEAR PHOTOCOPY OF THE OTHER CARRIER'S EXPLANATION OF BENEFITS FORM IS ACCEPTABLE IN PLACE OF THE ORIGINAL DOCUMENT.

FOR SERVICE RECEIVED OUTSIDE THE CAREFIRST BLUECROSS BLUESHIELD SERVICE AREA (MARYLAND, WASHINGTON DC AND NORTHERN VIRGINIA) THE CLAIM FORM AND ALL RELATED MATERIALS SHOULD BE SUBMITTED TO YOUR LOCAL BLUE CROSS AND BLUE SHIELD PLAN.

PLEASE REFER TO THE FOLLOWING PAGES FOR A LISTING OF THE LOCAL BLUES PLANS IN YOUR AREA.

#### BEFORE SUBMITTING YOUR CLAIM, PLEASE BE SURE THAT:

- 1. THE CLAIM FORM IS FULLY COMPLETED AND SIGNED.
- 2. THE ITEMIZED BILLS ARE ATTACHED.
- 3. YOU HAVE KEPT COPIES OF EACH DOCUMENT AND BILL FOR YOUR PERSONAL RECORDS

THE CLAIM FORM AND ALL RELATED MATERIALS SHOULD BE SUBMITTED TO: CAREFIRST BLUECROSS BLUESHIELD MAIL ADMINISTRATOR P.O. BOX 14116 LEXINGTON, KY 40512-4116



# Notice of Nondiscrimination and Availability of Language Assistance Services

CareFirst BlueCross BlueShield, CareFirst BlueChoice, Inc. and all of their corporate affiliates (CareFirst) comply with applicable federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability or sex. CareFirst does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

#### CareFirst:

Provides free aid and services to people with disabilities to communicate effectively with us, such as:
□ Qualified sign language interpreters
$\hfill \square$ Written information in other formats (large print, audio, accessible electronic formats, other formats)
Provides free language services to people whose primary language is not English, such as:  — Qualified interpreters
□ Information written in other languages

### If you need these services, please call 855-258-6518.

If you believe CareFirst 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 our CareFirst Civil Rights Coordinator by mail, fax or email. If you need help filing a grievance, our CareFirst Civil Rights Coordinator is available to help you.

To file a grievance regarding a violation of federal civil rights, please contact the Civil Rights Coordinator as indicated below. Please do not send payments, claims issues, or other documentation to this office.

### **Civil Rights Coordinator, Corporate Office of Civil Rights**

Mailing Address P.O. Box 8894

Baltimore, Maryland 21224

Email Address civilrightscoordinator@carefirst.com

Telephone Number 410-528-7820 Fax Number 410-505-2011

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 <a href="https://ocrportal.hhs.gov/ocr/portal/lobby.jsf">https://ocrportal.hhs.gov/ocr/portal/lobby.jsf</a> 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 800-368-1019, 800-537-7697 (TDD)

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

REV. (12/17)

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\* Registered trademark of the Blue Cross and Blue Shield Association. \*\* Registered trademark of CareFirst of Maryland, Inc.



### Foreign Language Assistance

Attention (English): This notice contains information about your insurance coverage. It may contain key dates and you may need to take action by certain deadlines. You have the right to get this information and assistance in your language at no cost. Members should call the phone number on the back of their member identification card. All others may call 855-258-6518 and wait through the dialogue until prompted to push 0. When an agent answers, state the language you need and you will be connected to an interpreter.

አማርኛ (Amharic) ማሳሰቢያ፦ ይህ ማስታወቂያ ስለ መድን ሽፋንዎ መረጃ ይዟል። ከተወሰኑ ቀነ-ገደቦቸ በፊት ሊሬጽሟቸው የሚገቡ ነገሮች ሊኖሩ ስለሚቸሉ እነዚህን ወሳኝ ቀናት ሊይዝ ይቸላል። ይኽን መረጃ የማግኘት እና ያለምንም ከፍያ በቋንቋዎ እንዛ የማግኘት መብት አለዎት። አባል ከሆኑ ከመታወቂያ ካርድዎ በስተጀርባ ላይ ወደተጠቀሰው የስልክ ቁጥር መደወል ይቸላሉ። አባል ካልሆኑ ደግሞ ወደ ስልክ ቁጥር 855-258-6518 ደውለው 0ን እንዲጫኑ እስኪነገርዎ ድረስ ንግግሩን መጠበቅ አለብዎ። አንድ ወኪል መልስ ሲሰጥዎ፣ የሚሬልጉትን ቋንቋ ያሳውቁ፣ ከዚያም ከተርጓሚ ጋር ይገናኛሉ።

Èdè Yorùbá (Yoruba) Ìtétíléko: Àkíyèsí yìí ní ìwífún nípa iṣé adójútòfò rẹ. Ó le ní àwọn déètì pàtó o sì le ní láti gbé ìgbésè ní àwọn ojó gbèdéke kan. O ni ètó láti gba ìwífún yìí àti ìrànlówó ní èdè rẹ lófèé. Àwọn omọ-ẹgbé gbódò pe nómbà fóònù tó wà léyìn káàdì ìdánimò wọn. Àwọn míràn le pe 855-258-6518 kí o sì dúró nípasè ìjíròrò títí a ó fi sọ fún ọ láti tẹ 0. Nígbàtí aṣojú kan bá dáhùn, sọ èdè tí o fé a ó sì so ó pò mó ògbufò kan.

Tiếng Việt (Vietnamese) Chú ý: Thông báo này chứa thông tin về phạm vi bảo hiểm của quý vị. Thông báo có thể chứa những ngày quan trọng và quý vị cần hành động trước một số thời hạn nhất định. Quý vị có quyền nhận được thông tin này và hỗ trợ bằng ngôn ngữ của quý vị hoàn toàn miễn phí. Các thành viên nên gọi số điện thoại ở mặt sau của thẻ nhận dạng. Tất cả những người khác có thể gọi số 855-258-6518 và chờ hết cuộc đối thoại cho đến khi được nhắc nhấn phím 0. Khi một tổng đài viên trả lời, hãy nêu rõ ngôn ngữ quý vị cần và quý vị sẽ được kết nối với một thông dịch viên.

Tagalog (Tagalog) Atensyon: Ang abisong ito ay naglalaman ng impormasyon tungkol sa nasasaklawan ng iyong insurance. Maaari itong maglaman ng mga pinakamahalagang petsa at maaaring kailangan mong gumawa ng aksyon ayon sa ilang deadline. May karapatan ka na makuha ang impormasyong ito at tulong sa iyong sariling wika nang walang gastos. Dapat tawagan ng mga Miyembro ang numero ng telepono na nasa likuran ng kanilang identification card. Ang lahat ng iba ay maaaring tumawag sa 855-258-6518 at maghintay hanggang sa dulo ng diyalogo hanggang sa diktahan na pindutin ang 0. Kapag sumagot ang ahente, sabihin ang wika na kailangan mo at ikokonekta ka sa isang interpreter.

Español (Spanish) Atención: Este aviso contiene información sobre su cobertura de seguro. Es posible que incluya fechas clave y que usted tenga que realizar alguna acción antes de ciertas fechas límite. Usted tiene derecho a obtener esta información y asistencia en su idioma sin ningún costo. Los asegurados deben llamar al número de teléfono que se encuentra al reverso de su tarjeta de identificación. Todos los demás pueden llamar al 855-258-6518 y esperar la grabación hasta que se les indique que deben presionar 0. Cuando un agente de seguros responda, indique el idioma que necesita y se le comunicará con un intérprete.

Русский (Russian) Внимание! Настоящее уведомление содержит информацию о вашем страховом обеспечении. В нем могут указываться важные даты, и от вас может потребоваться выполнить некоторые действия до определенного срока. Вы имеете право бесплатно получить настоящие сведения и сопутствующую помощь на удобном вам языке. Участникам следует обращаться по номеру телефона, указанному на тыльной стороне идентификационной карты. Все прочие абоненты могут звонить по номеру 855-258-6518 и ожидать, пока в голосовом меню не будет предложено нажать цифру «0». При ответе агента укажите желаемый язык общения, и вас свяжут с переводчиком.

हिन्दी (Hindi) ध्यान दें: इस सूचना में आपकी बीमा कवरेज के बारे में जानकारी दी गई है। हो सकता है कि इसमें मुख्य तिथियों का उल्लेख हो और आपके लिए किसी नियत समय-सीमा के भीतर काम करना ज़रूरी हो। आपको यह जानकारी और संबंधित सहायता अपनी भाषा में निःशुल्क पाने का अधिकार है। सदस्यों को अपने पहचान पत्र के पीछे दिए गए फ़ोन नंबर पर कॉल करना चाहिए। अन्य सभी लोग 855-258-6518 पर कॉल कर सकते हैं और जब तक 0 दबाने के लिए न कहा जाए, तब तक संवाद की प्रतीक्षा करें। जब कोई एजेंट उत्तर दे तो उसे अपनी भाषा बताएँ और आपको व्याख्याकार से कनेक्ट कर दिया जाएगा।

*Bǎsóò-wùdù* (*Bassa*) Tò Đùǔ Cáo! Bỗ nìà ke bá nyo bẽ ké m̀ gbo kpá bó nì fuà-fuá-tiǐn nyee jè dyí. Bỗ nìà ke bédé wé jéé bẽ m̀ ké dẽ wa mó m̀ ké nyuee nyu hwè bế wé bẽa ké zi. O mò nì kpé bế m̀ ké bỗ nìà ke kè gbo-kpá-kpá m̀ mɔ́ee dyé dé nì bídí-wudu mú bế m̀ ké se wídí dò péè. Kpooò nyo bẽ me dá fuun-nɔ́bà nìà dé waà I.D. káàò deín nye. Nyo tòò seín me dá nɔ̂bà nìà ke: 855-258-6518, ké m̀ me fò tee bế wa kée m̀ gbo cẽ bế m̀ ké nɔ̀bà mòà 0 kee dyi pàdàìn hwè. O jǔ ké nyo dò dyi m̀ gỗ jǔǐn, po wudu m̀ mɔ́ poe dyie, ké nyo dò mu bó nììn bế o ké nì wuduò mú zà.

বাংলা (Bengali) লক্ষ্য করুন: এই নোটিশে আপনার বিমা কভারেজ সম্পর্কে তথ্য রয়েছে। এর মধ্যে গুরুত্বপূর্ণ তারিখ থাকতে পারে এবং নির্দিষ্ট তারিখের মধ্যে আপনাকে পদক্ষেপ নিতে হতে পারে। বিনা খরচে নিজের ভাষায় এই তথ্য পাওয়ার এবং সহায়তা পাওয়ার অধিকার আপনার আছে। সদস্যদেরকে তাদের পরিচয়পত্রের পিছনে থাকা নম্বরে কল করতে হবে। অন্যেরা 855-258-6518 নম্বরে কল করে 0 টিপতে না বলা পর্যন্ত অপেক্ষা করতে পারেন। যখন কোনো এজেন্ট উত্তর দেবেন তখন আপনার নিজের ভাষার নাম বলুন এবং আপনাকে দোভাষীর সঙ্গে সংযুক্ত করা হবে।

اردو (Urdu) توجہ :یہ نوٹس آپ کے انشورینس کوریج سے متعلق معلومات پر مشتمل ہے۔ اس میں کلیدی تاریخیں ہو سکتی ہیں اور ممکن ہے کہ آپ کو مخصوص آخری تاریخوں تک کارروائی کرنے کی ضرورت پڑے۔ آپ کے پاس یہ معلومات حاصل کرنے اور بغیر خرچہ کیے اپنی زبان میں مدد حاصل کرنے کا حق ہے۔ ممبران کو اپنے شناختی کارڈ کی پشت پر موجود فون نمبر پر کال کرنی چاہیے۔ سبھی دیگر لوگ 855-258پر کال کر سکتے ہیں اور 0 دبانے کو کہے جانے تک انتظار کریں۔ ایجنٹ کے جواب دینے پر اپنی مطلوبہ زبان بتائیں اور مترجم سے مربوط ہو جائیں گے۔

فارسی (Farsi) توجه: این اعلامیه حاوی اطلاعاتی درباره پوشش بیمه شما است. ممکن است حاوی تاریخ های مهمی باشد و لازم است تا تاریخ مقرر شده خاصی اقدام کنید. مقرر شده خاصی اقدام کنید. شما از این حق برخوردار هستید تا این اطلاعات و راهنمایی را به صورت رایگان به زبان خودتان دریافت کنید. اعضا باید با شماره اعضا باید با شماره مدر پشت کارت شناسایی شان تماس بگیرند. سایر افراد می توانند با شماره محلی در پشت کارت شناسایی شان تماس بگیرند و منتظر بمانند تا از آنها خواسته شود عدد 0 را فشار دهند. بعد از پاسخگویی توسط یکی از اپراتور ها، زبان مورد نیاز را تنظیم کنید تا به مترجم مربوطه وصل شوید.

اللغة العربية (Arabic) تنبيه :يحتوي هذا الإخطار على معلومات بشأن تغطيتك التأمينية، وقد يحتوي على تواريخ مهمة، وقد تحتاج إلى اتخاذ إجراءات بحلول مواعيد نهائية محددة .يحق لك الحصول على هذه المساعدة والمعلومات بلغتك بدون تحمل أي تكلفة .ينبغي على الأعضاء الاتصال على رقم الهاتف المذكور في ظهر بطاقة تعريف الهوية الخاصة بهم يمكن للآخرين الاتصال على الرقم 855-258 والانتظار خلال المحادثة حتى يطلب منهم الضغط على رقم .0 عند إجابة أحد الوكلاء، اذكر اللغة التي تحتاج إلى التواصل بها وسيتم توصيلك بأحد المترجمين الفوريين.

中文繁体(Traditional Chinese) 注意:本聲明包含關於您的保險給付相關資訊。本聲明可能包含重要日期及您在特定期限之前需要採取的行動。您有權利免費獲得這份資訊,以及透過您的母語提供的協助服務。會員請撥打印在身分識別卡背面的電話號碼。其他所有人士可撥打電話 855-258-6518, 並等候直到對話提示按下按鍵 0。當接線生回答時,請說出您需要使用的語言,這樣您就能與口譯人員連線。

Igbo (Igbo) Nrubama: Okwa a nwere ozi gbasara mkpuchi nchekwa onwe gi. O nwere ike inwe ubochi ndi di mkpa, i nwere ike ime ihe tupu ufodu ubochi njedebe. I nwere ikike inweta ozi na enyemaka a n'asusu gi na akwughi ugwo o bula. Ndi otu kwesiri ikpo akara ekwenti di n'azu nke kaadi njirimara ha. Ndi ozo niile nwere ike ikpo 855-258-6518 wee chere ububo ahu ruo mgbe amanyere ipi 0. Mgbe onye nnochite anya zara, kwuo asusu i choro, a ga-ejiko gi na onye okowa okwu.

Deutsch (German) Achtung: Diese Mitteilung enthält Informationen über Ihren Versicherungsschutz. Sie kann wichtige Termine beinhalten, und Sie müssen gegebenenfalls innerhalb bestimmter Fristen reagieren. Sie haben das Recht, diese Informationen und weitere Unterstützung kostenlos in Ihrer Sprache zu erhalten. Als Mitglied verwenden Sie bitte die auf der Rückseite Ihrer Karte angegebene Telefonnummer. Alle anderen Personen rufen bitte die Nummer 855-258-6518 an und warten auf die Aufforderung, die Taste 0 zu drücken. Geben Sie dem Mitarbeiter die gewünschte Sprache an, damit er Sie mit einem Dolmetscher verbinden kann.

Français (French) Attention: cet avis contient des informations sur votre couverture d'assurance. Des dates importantes peuvent y figurer et il se peut que vous deviez entreprendre des démarches avant certaines échéances. Vous avez le droit d'obtenir gratuitement ces informations et de l'aide dans votre langue. Les membres doivent appeler le numéro de téléphone figurant à l'arrière de leur carte d'identification. Tous les autres peuvent appeler le 855-258-6518 et, après avoir écouté le message, appuyer sur le 0 lorsqu'ils seront invités à le faire. Lorsqu'un(e) employé(e) répondra, indiquez la langue que vous souhaitez et vous serez mis(e) en relation avec un interprète.

한국어(Korean) 주의: 이 통지서에는 보험 커버리지에 대한 정보가 포함되어 있습니다. 주요 날짜 및 조치를 취해야 하는 특정 기한이 포함될 수 있습니다. 귀하에게는 사용 언어로 해당 정보와 지원을 받을 권리가 있습니다. 회원이신 경우 ID 카드의 뒷면에 있는 전화번호로 연락해 주십시오. 회원이 아니신 경우 855-258-6518 번으로 전화하여 0을 누르라는 메시지가 들릴 때까지 기다리십시오. 연결된 상담원에게 필요한 언어를 말씀하시면 통역 서비스에 연결해 드립니다.

Diné Bizaad (Navajo) Ge': Díí bee ił hane'ígíí bii' dahóló bee éédahózin béeso ách'ááh naanil ník'ist'i'ígíí bá. Bii' dahólóó doo íiyisíí yoolkáálígíí dóó t'áádoo le'é ádadooly(ílígíí da yókeedgo t'áá doo bee e'e'aahí ájiil'(íh. Bee ná ahóót'i' díí bee ił hane' dóó niká'ádoowoł t'áá nínizaad bee t'áá jiik'é. Atah danilínígíí béésh bee hane'é bee wółta'ígíí nitł'izgo bee nee hódolzinígíí bikéédéé' bikáá' bich'i' hodoonihjí'. Aadóó náánáła' éí koji' dahódoolnih 855-258-6518 dóó yii diiłts'(il yałtí'ígíí t'áá níléíjí áádóó éí bikéé'dóó naasbąąs bił adidiilchił. Áká'ánidaalwó'ígíí neidiitáágo, saad bee yániłt'i'ígíí yii diikił dóó ata' halne'é lá níká'ádoolwoł.