Keystone Point of Service

TYPE OR PRINT

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

INFORMATION WE NEED FROM YOU

SECTION A

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.

SIGNED - EMPLOYEE OR SPOUSE	DATE	THIS SECTION MUST BE SIGNED BEFORE A CLAIM MAY BE PROCESSED.
X		

SECTION B

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 ☐ M ☐ F | 5. PATIENT'S RELATION TO EMPLOYEE ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER

6. SUBSCRIBER'S NAME (FIRST, M.I., LAST)

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 ☐ YES ☐ NO | B. AN ACCIDENT ☐ YES ☐ NO | IF AN ACCIDENT | DATE | TIME ☐ AM ☐ PM | DESCRIPTION (HOW AND WHERE)

9. SUBSCRIBER'S SOCIAL SECURITY NUMBER | 10. GROUP NAME (EMPLOYER'S COMPANY NAME)

11. IS PATIENT COVERED BY ANY OTHER HEALTH PLAN? ☐ YES ☐ NO | IF YES | NAME OF POLICYHOLDER | POLICY NUMBER | NAME AND ADDRESS OF INSURANCE COMPANY

12. IS PATIENT COVERED BY MEDICARE? ☐ YES ☐ NO

13. IS CHILD FULL-TIME STUDENT? ☐ YES ☐ 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

SECTION C

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: PROCEDURE CODE	MOD1	MOD2	EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES	D. DIAGNOSIS CODE OR UNITS	E. CHARGES

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 ATTACHED 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 RECEIPT CENTER P.O. BOX 211184 EAGAN, MN 55121	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
12	HOME
21	INPATIENT HOSPITAL
22	OUTPATIENT HOSPITAL
23	EMERGENCY ROOM (HOSPITAL)
24	AMBULATORY SURGICAL CENTER (ASC)
25	BIRTHING CENTER
26	MILITARY TREATMENT FACILITY
31	SKILLED NURSING FACILITY (SNF)
32	NURSING FACILITY
33	CUSTODIAL CARE FACILITY
34	HOSPICE
41	AMBULANCE (LAND)
42	AMBULANCE (AIR OR WATER)
51	INPATIENT PSYCHIATRIC FACILITY
52	PSYCHIATRIC FACILITY PARTIAL HOSPITALIZATION
53	COMMUNITY MENTAL HEALTH CENTER
54	INTERMEDIATE CARE FACILITY/MENTALLY RETARDED
55	RESIDENTIAL SUBSTANCE ABUSE TREATMENT FACILITY
56	PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY
61	COMPREHENSIVE INPATIENT REHAB FACILITY
62	COMPREHENSIVE OUTPATIENT REHAB FACILITY
65	END STAGE RENAL DISEASE TREATMENT CENTER
71	STATE OR LOCAL PUBLIC HEALTH CENTER
72	RURAL HEALTH CLINIC
81	INDEPENDENT LABORATORY
99	OTHER UNLISTED FACILITY

Language Assistance Services

Spanish: ATENCIÓN: Si habla español, cuenta con servicios de asistencia en idiomas disponibles de forma gratuita para usted. Llame al 1-800-275-2583 (TTY: 711).

Chinese: 注意：如果您讲中文，您可以得到免费的语言协助服务。致电 1-800-275-2583。

Korean: 안내사항: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-275-2583 번으로 전화하십시오.

Portuguese: ATENÇÃO: se você fala português, encontram-se disponíveis serviços gratuitos de assistência ao idioma. Ligue para 1-800-275-2583.

Gujarati: સૂચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. 1-800-275-2583 કોલ કરો.

Vietnamese: LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi sẽ cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho bạn. Hãy gọi 1-800-275-2583.

Russian: ВНИМАНИЕ: Если вы говорите по-русски, то можете бесплатно воспользоваться услугами перевода. Тел.: 1-800-275-2583.

Polish UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-275-2583.

Italian: ATTENZIONE: Se lei parla italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-275-2583.

Arabic:
ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية متاحة لك بالمجان. اتصل برقم 1-800-275-2583.

French Creole: ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-275-2583.

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga serbisyo na tulong sa wika nang walang bayad. Tumawag sa 1-800-275-2583.

French: ATTENTION: Si vous parlez français, des services d'aide linguistique-vous sont proposés gratuitement. Appelez le 1-800-275-2583.

Pennsylvania Dutch: BASS UFF: Wann du Pennsylvania Deitsch schwetzscht, kannscht du Hilf griege in dei eegni Schprooch unni as es dich ennich eppes koschte zellt. Ruf die Nummer 1-800-275-2583.

Hindi: ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। कॉल करें 1-800-275-2583।

German: ACHTUNG: Wenn Sie Deutsch sprechen, können Sie kostenlos sprachliche Unterstützung anfordern. Wählen Sie 1-800-275-2583.

Japanese: 備考：母国語が日本語の方は、言語アシスタンスサービス（無料）をご利用いただけます。1-800-275-2583へお電話ください。

Persian (Farsi):
توجه: اگر فارسی صحبت می کنید، خدمات ترجمه به صورت رایگان برای شما فراهم می باشد. با شماره 1-800-275-2583 تماس بگیرید.

Navajo: Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh. Hódíílnih kojį' 1-800-275-2583.

Urdu:
توجہ درکارہے: اگر آپ اردو زبان بولتے ہیں، تو آپ کے لئے مفت میں زبان معاون خدمات دستیاب ہیں۔ کال کریں 1-800-275-2583.

Mon-Khmer, Cambodian: សូមមេត្តាចាប់អារម្មណ៍៖ ប្រសិនបើអ្នកនិយាយភាសាមន-ខ្មែរ ឬភាសាខ្មែរ នោះជំនួយផ្នែកភាសានឹងមានផ្តល់ជូនដល់លោកអ្នកដោយឥតគិតថ្លៃ។ ទូរសព្ទទៅលេខ 1-800-275-2583។

Discrimination is Against the Law

This Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. This Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

This Plan provides:

- Free aids and services to people with disabilities to communicate effectively with us, such as: qualified sign language interpreters, and written information in other formats (large print, audio, accessible electronic formats, other formats).
- Free language services to people whose primary language is not English, such as: qualified interpreters and information written in other languages.

If you need these services, contact our Civil Rights Coordinator. If you believe that This Plan 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 Civil Rights Coordinator. You can file a grievance in the following ways: In person or by mail: ATTN: Civil Rights Coordinator, 1901 Market Street, Philadelphia, PA 19103, By phone: 1-888-377-3933 (TTY: 711) By fax: 215-761-0245, By email: civilrightscoordinator@1901market.com. If you need help filing a grievance, our Civil Rights 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, DC 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*.