DGA-PRODUCER PENSION & HEALTH

INSTRUCTIONS FOR MEDICAL CLAIM FORM FOR NON-CALIFORNIA CLAIMS

These instructions will advise you on how to prepare the attached Medical Claim Form to submit your professional (non-hospital) claim to your local Blue Cross/Blue Shield office.

WHO SHOULD USE THIS FORM

- If you are submitting a Non-California claim to your local Blue Cross/Blue Shield office and the medical bill from your provider is not in the same format as the attached Medical Claim Form, you should attach a Medical Claim Form to each itemized bill that you submit.
- Medical providers, if you are filing a claim on behalf of a participant but you do not use the same CMS-1500 format as the attached Medical Claim Form. This form replaces the HCFA 1500.

FILLING OUT THE FORM

Be sure to complete sections 1a, 2, 3, 4, 6, 7, and 11 as shown in the example below. The remaining sections may be left blank.

1. MEDICARE ☐ (Medicare#) MEDICAID ☐ (Medicaid#) TRICARE ☐ (ID#/DoD#) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (ID#) FECA BLK LUNG ☐ (ID#) OTHER ☐ (ID#)		1a. INSURED'S I.D. NUMBER (For Program in Item 1) DGA12345678J
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) DOE, JANE	3. PATIENT'S BIRTH DATE MM DD YY SEX 01 21 60 M ☐ F X	4. INSURED'S NAME (Last Name, First Name, Middle Initial) DOE, JOHN
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse X Child ☐ Other ☐	7. INSURED'S ADDRESS (No., Street) 123 MAIN STREET
CITY STATE	8. RESERVED FOR NUCC USE	CITY NEW YORK STATE NY
ZIP CODE TELEPHONE (Include Area Code) ( )		ZIP CODE 10022 TELEPHONE (Include Area Code) ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER 276945M001

- Box 1a/Insured's I.D. Number. Be sure to enter your ID number as it appears on your Health Plan ID card, including the "DGA" at the beginning and the "J" at the end. Do not use your social security number.
- Box 2/Patient's Name. Enter the name exactly as it appears on the Health Plan ID card. If a dependent child does not have a Health Plan ID card issued in their name, enter the child's name exactly as it is on file with the Health Plan.
- Box 4/Insured's Name. (See Box 2 above.) If the insured person is also the patient, be sure to write the full name in both Box 2 and Box 4. Do not write "self" or "same" instead of your name.
- Box 7/Insured's Address. Be sure that your home address is entered exactly as the home address on file with the Health Plan.
- Box 11/Insured's Policy Group or FECA Number. Be sure to enter the Group Number that begins with 276945 from your Health Plan ID card.

WHERE TO SUBMIT THE FORM

Claims should be sent to the Blue Cross/Blue Shield office in the area where the services were provided. For example, if you live in New York but visit a doctor in New Jersey, your claim should be submitted to the Blue Cross/Blue Shield office in New Jersey. To find the address of your local Blue Cross/Blue Shield office, please visit www.dgaplans.org/healthclaims.htm.

DGA-PPHP Direct Submission Form

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

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CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE ☐ (Medicare#) MEDICAID ☐ (Medicaid#) TRICARE ☐ (ID#/DoD#) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (ID#) FECA BLK LUNG ☐ (ID#) OTHER ☐ (ID#)		1a. INSURED'S I.D. NUMBER (For Program in Item 1)
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐	7. INSURED'S ADDRESS (No., Street)
CITY STATE	8. RESERVED FOR NUCC USE	CITY STATE
ZIP CODE TELEPHONE (Include Area Code) ( )		ZIP CODE TELEPHONE (Include Area Code) ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) ☐ YES ☐ NO	a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? ☐ YES ☐ NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO *If yes*, complete items 9, 9a, and 9d.
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

PHYSICIAN OR SUPPLIER INFORMATION

ATTENTION BLUECARD PROCESSOR:

1 THIS IDENTIFIES THE INSURED AND THE
2 GROUP FOR THE *ATTACHED BILL*.
3
4 PLEASE KEEP THIS TOGETHER WITH THE
5 *ATTACHED ITEMIZED BILL*.
6

Thank you.

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE