

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>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.</i>									
	SIGNED - EMPLOYEE OR SPOUSE X					DATE		THIS SECTION MUST BE SIGNED BEFORE A CLAIM MAY BE PROCESSED.		
	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 <input type="checkbox"/> M <input type="checkbox"/> F		5. PATIENT'S RELATION TO EMPLOYEE <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> 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 <input type="checkbox"/> YES <input type="checkbox"/> NO		B. AN ACCIDENT <input type="checkbox"/> YES <input type="checkbox"/> NO		IF AN ACCIDENT	DATE	TIME <input type="checkbox"/> AM <input type="checkbox"/> 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? <input type="checkbox"/> YES <input type="checkbox"/> NO			IF YES		NAME OF POLICYHOLDER		NAME AND ADDRESS OF INSURANCE COMPANY		
12. IS PATIENT COVERED BY MEDICARE? <input type="checkbox"/> YES <input type="checkbox"/> NO			13. IS CHILD FULL-TIME STUDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		<i>I authorize the release of any information necessary to process this request.</i>					
							14. SIGNED (PATIENT OR PARENT IF MINOR) X			
SECTION B										
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										
SECTION C										
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			
TAXPAYER ID NO.			25. SIGNATURE OF PHYSICIAN OR SUPPLIER				DATE			
24. BALANCE DUE										
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.

KE100 - KPOS d (11/07)

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 SERVICING CENTER
PO BOX 69353
HARRISBURG, PA 17106-9353

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