



BlueCross BlueShield

Health Benefits Claim Form

Federal Employee Program

Please review the instructions on the reverse side of this form before completing.

1. PATIENT INFORMATION, 1A. ENROLLMENT INFORMATION, 1B. PATIENT'S NAME, 1C. PATIENT'S DATE OF BIRTH, 1D. PATIENT'S SEX, 1E. NAME OF ENROLLEE OR POLICY HOLDER, 1F. DATE OF BIRTH, 1G. PATIENT'S RELATIONSHIP TO ENROLLEE, 1H. ENROLLEE'S CURRENT ADDRESS, 1I. EMAIL ADDRESS

PLEASE COMPLETE INFORMATION BELOW ONLY IF IT HAS CHANGED SINCE YOU LAST GAVE IT TO US. IF NO CHANGES, GO TO #5.

2. OTHER HEALTH INSURANCE Is the patient covered by additional health insurance through an employer, a group such as a professional organization, or any other group health insurance, including other Blue Cross and/or Blue Shield Coverage? Yes No If answered yes, complete 2A through 2E; if answered no, go to Section 3.

2A. NAME AND ADDRESS OF INSURING COMPANY, 2B. EFFECTIVE DATE, TERMINATION DATE

2C. NAME OF POLICY HOLDER AND HIS/HER EMPLOYER, 2D. DATE OF BIRTH, 2E. IDENTIFICATION NUMBER

3. MEDICARE PLEASE COMPLETE THIS SECTION ON MEDICARE REGARDLESS OF THE PATIENT'S AGE If you are covered by a Medicare HMO/Prepaid Plan, please leave Sections 3A and 3B Blank

3A. MEDICARE PART A (Hospital Insurance), 3B. MEDICARE PART B (Medical Insurance), 3C. MEDICARE HMO/ PREPAID PLAN, 3D. If the patient is eligible for Medicare due to End-Stage Renal Disease, please indicate the beginning date of renal treatment or transplant.

4. EMPLOYMENT, 4A. Is the patient presently employed? If the patient is retired from the Federal Government, but still employed, please complete 4B

4B. NAME AND ADDRESS OF COMPANY OR GOVERNMENT AGENCY (Street, City, State, and ZIP Code)

5. DIAGNOSIS Describe illness, injury or symptoms requiring treatment. If illness, injury or symptoms are related to an accident, please complete 5A, 5B and 5C.

5A. DATE OF ACCIDENT, 5B. TIME OF ACCIDENT, 5C. LOCATION OF ACCIDENT Was the accident caused by someone else? Yes No

6. CHARGES Please list below those charges that you are claiming for benefits. Use a separate line for each type of service or provider. PLEASE ATTACH ITEMIZED BILLS

Table with 5 columns: NAME OF PROVIDER MAKING CHARGE, DESCRIPTION OF CHARGE, DATE OF SERVICE OR PURCHASE: FROM, DATE OF SERVICE OR PURCHASE: TO, CHARGE

I certify the above is complete and correct and that I am claiming benefits only for charges incurred as listed above. Authorization is hereby given to any provider of service, which participated in any way the medical care or services provided, to release to the Blue Cross and/or Blue Shield Plan any medical information which they deem necessary to adjudicate this claim.

7. SIGNATURE OF PATIENT OR AUTHORIZED REPRESENTATIVE (Signature, Date, Best telephone number to call including area code)

Failure to sign this claim form may delay processing.



Receipt

Elizabeth Thompson
 2920 Bluff St, Apt 224, Boulder, CO, 80301
 Tel: +14052505552
 Email: elizjthom@gmail.com

Items and Payments			
Items	Details		Amount
September 5, 2023 - 12:00pm, Acupuncture Appointment (60 minutes) Kaely Shull LAc, LCh, Dipl. OM, MSOM, License #2647	Invoice #498-P01 Friends & Family Discount		\$76.50
September 12, 2023 - 9:00am, Acupuncture Appointment (60 minutes) Kaely Shull LAc, LCh, Dipl. OM, MSOM, License #2647	Invoice #493-P01 Friends & Family Discount		\$76.50
September 21, 2023 - 4:00pm, Acupuncture Appointment (60 minutes) Kaely Shull LAc, LCh, Dipl. OM, MSOM, License #2647	Invoice #513-P01 Friends & Family Discount		\$76.50
October 3, 2023 - 5:00pm, Acupuncture Appointment (60 minutes) Kaely Shull LAc, LCh, Dipl. OM, MSOM, License #2647	Invoice #521-P01 Friends & Family Discount		\$76.50
diagnosis codes: G25.81 and G47.00 procedure code: CPT 97810			Subtotal \$306.00
			Payer Total \$306.00
Payments			
Tuesday October 3, 2023 - 6:17pm	Credit Card	Elizabeth Thompson ch_3Nxlm4JnuK6juLtD01mZ6bMR	\$306.00
Date and Time:	October 3, 2023 - 6:17pm		
Status:	authorized succeeded		
Amount:	\$306.00		
Card Number:	VISA ending in 3815		
Transaction ID:	399		
Authorization:	ch_3Nxlm4JnuK6juLtD01mZ6bMR		



Elizabeth Thompson
 2920 Bluff St, Apt 224, Boulder, CO, 80301
 Tel: +14052505552
 Email: elizjthom@gmail.com

Receipt

Items and Payments			
Items	Details		Amount
October 17, 2023 - 5:00pm, Acupuncture Appointment (60 minutes) Kaely Shull LAc, LCh, Dipl. OM, MSOM, License #2647	Invoice #533-P01 Friends & Family Discount		\$76.50
Subtotal			\$76.50
Payer Total			\$76.50
Payments			
Monday October 23, 2023 - 4:39pm	Credit Card	Elizabeth Thompson ch_3O4WmcJnuK6juLtD1Pw94WnE	\$76.50
Date and Time:	October 23, 2023 - 4:39pm		
Status:	authorized succeeded		
Amount:	\$76.50		
Card Number:	VISA ending in 3815		
Transaction ID:	411		
Authorization:	ch_3O4WmcJnuK6juLtD1Pw94WnE		