Federal Employee Program®

Health Benefits Claim Form

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

1. PATIENT INFORMATION	**1A.** ENROLLMENT INFORMATION Enrollment Code Identification Number		
1B. PATIENT'S NAME (First, Middle Initial and Last)		**1C.** PATIENT'S DATE OF BIRTH (mm/dd/yyyy)	**1D.** PATIENT'S SEX Male Female
1E. NAME OF ENROLLEE OR POLICY HOLDER (First, Middle Initial and Last)	**1F.** DATE OF BIRTH (mm/dd/yyyy)	**1G.** PATIENT'S RELATIONSHIP TO ENROLLEE Self Spouse Child	
1H. ENROLLEE'S CURRENT ADDRESS (Street, City, State and ZIP Code)			CHECK IF NEW 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 (Street, City, State and ZIP Code)	**2B.** EFFECTIVE DATE (mm/dd/yyyy) TERMINATION DATE (mm/dd/yyyy)	
2C. NAME OF POLICY HOLDER AND HIS/HER EMPLOYER (First, Middle Initial and Last)	**2D.** DATE OF BIRTH (mm/dd/yyyy)	**2E.** IDENTIFICATION NUMBER (Include all letters and numbers)

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.
Yes No If yes, effective date (mm/dd/yyyy)	Yes No If yes, effective date (mm/dd/yyyy)	Yes No If yes, effective date (mm/dd/yyyy)	(mm/dd/yyyy)

4. **EMPLOYMENT**	**4A.** Is the patient presently employed? If the patient is retired from the Federal Government, but still employed, please complete 4B Yes No
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 (mm/dd/yyyy)	**5B.** TIME OF ACCIDENT AM PM	5C. LOCATION OF ACCIDENT Was the accident caused by someone else? Yes No At Home At Work Motor vehicle accident Other If a Motor vehicle accident, what state Please Explain

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

NAME OF PROVIDER MAKING CHARGE (Doctor, Hospital, etc. Two or more bills from the same provider may be entered on one line if they are for the same type of service.)	**DESCRIPTION OF CHARGE** (Office Visits, Therapy from Mental Conditions, etc.)	**DATE OF SERVICE OR PURCHASE: FROM** (If there is only one date, indicate it as the "FROM DATE".)	**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

Elizabeth Thompson

(Signature) (Date) (Best telephone number to call including area code)

Failure to sign this claim form may delay processing.

Blue Sky Family Acupuncture
1148 W Dillon Rd, Suite 1, Louisville, CO, 80027
Tel: 303-578-0869 Email: kaely@blueskyfamilyacupuncture.com
NPI #1881473213

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

Receipt

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_3NxIm4JnuK6juLtD01mZ6bMR	$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_3NxIm4JnuK6juLtD01mZ6bMR

Blue Sky Family Acupuncture
1148 W Dillon Rd, Suite 1, Louisville, CO, 80027
Tel: 303-578-0869 Email: kaely@blueskyfamilyacupuncture.com

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