



Star Unit PP-05Y  
 Horizon BCBSNJ  
 3 Penn Plaza East  
 Newark, NJ 07105-2200

Horizon Blue Cross Blue Shield of New Jersey

FOR COPAY REIMBURSEMENTS ONLY, PLEASE CHECK THE FOLLOWING:

	POS	TOS	CPT	TAXID#
<input type="checkbox"/> MEDICAL	3	9	99199	7802COPAYREIMO
<input type="checkbox"/> PHARMACY	3	9	A9140	780200PHARMACY

## Copayment Reimbursement Form

<b>I. POLICYHOLDER</b>	1. POLICYHOLDER'S NAME (Last, First, Middle Initial) (PLEASE TYPE OR PRINT)		2. POLICYHOLDER'S IDENTIFICATION NUMBER PREFIX (if any)      NUMBER PORTION      SUFFIX (if any)			
	3. POLICYHOLDER'S ADDRESS (No., Street)		CITY	STATE      ZIP CODE		
	4. TELEPHONE NUMBER (Include Area Code) (      )	5. POLICYHOLDER'S SOCIAL SECURITY NUMBER	6. POLICYHOLDER'S BIRTH DATE Month      Day      Year	6a. POLICYHOLDER'S SEX <input type="checkbox"/> Male <input type="checkbox"/> Female		
	7. EMPLOYER'S NAME		8. IF THIS IS A GROUP POLICY, INDICATE THE GROUP NUMBER			
<b>II. PATIENT</b>	9. PATIENT'S NAME (Last, First, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO:			
	11. PATIENT'S BIRTH DATE Month      Day      Year	11a. PATIENT'S SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	12. PATIENT STATUS <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Other	a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO		
	13. PATIENT'S RELATIONSHIP TO POLICYHOLDER <input type="checkbox"/> Policy Holder <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other		14. IS PATIENT <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Employed <input type="checkbox"/> Part-Time Student	b. AUTO ACCIDENT <input type="checkbox"/> YES <input type="checkbox"/> NO      STATE IN WHICH AUTO ACCIDENT OCCURRED: _____		
				c. OTHER ACCIDENT <input type="checkbox"/> YES <input type="checkbox"/> NO		
<b>III. COORDINATION OF BENEFITS</b>	15. DOES THE PATIENT HAVE OTHER HEALTH INSURANCE? IF YES, COMPLETE ITEMS 15a-h <input type="checkbox"/> YES <input type="checkbox"/> NO		15a. IF MEDICARE, CHECK HERE AND ATTACH EOMB <input type="checkbox"/>			
	15b. OTHER POLICYHOLDER'S NAME (Last, First, Middle Initial)		15c. OTHER POLICYHOLDER'S BIRTH DATE Month      Day      Year	15d. OTHER POLICYHOLDER'S SEX <input type="checkbox"/> Male <input type="checkbox"/> Female		
	15e. OTHER POLICYHOLDER'S ADDRESS (No., Street)		CITY	STATE	ZIP CODE	
	15f. OTHER INSURANCE PLAN'S NAME		15g. OTHER POLICYHOLDER'S IDENTIFICATION NUMBER AND GROUP NUMBER			
	15h. OTHER INSURANCE PLAN'S ADDRESS (No., Street)		CITY	STATE	ZIP CODE	
<b>IV. AUTHORIZATION</b>	16. I certify that the information provided on this claim form is correct and complete, and that I am claiming benefits only for charges actually incurred by the patient named. I authorize any hospital, physician or other provider who participated in the care and treatment of the patient to release to Horizon Blue Cross Blue Shield of New Jersey, all medical or other information requested for the processing of this claim form. I hereby agree to reimburse Horizon Blue Cross Blue Shield of New Jersey, in full should this claim be incorrectly paid.					
_____ AUTHORIZED SIGNATURE		_____ DATE	_____ (AREA CODE) HOME PHONE	_____ (AREA CODE) WORK PHONE		

**WHEN YOU ARE SUBMITTING EXPENSES FOR MORE THAN ONE FAMILY MEMBER, PLEASE USE A SEPARATE CLAIM FORM FOR EACH PERSON.**