NEW JERSEY TRANSIT
EMPLOYEES HEALTH BENEFIT PROGRAM
FOR ON THE JOB INJURIES ONLY

"To assist us in processing your claims more efficiently, please submit your claims monthly or when you have bills totaling $200 or more."

DO NOT USE STAPLES

Instructions and Mailing Information on the Reverse Side.

EMPLOYEE - Complete This Section

A. EMPLOYER: New Jersey Transit Rail | DATE HIRED | EMPLOYMENT STATUS ☐ HOURLY ☐ SALARIED ☐ RETIRED

B. PLANT LOCATION/DIVISION | ACCOUNT NUMBER | C. HAVE YOU TERMINATED EMPLOYMENT WITH EMPLOYER LISTED ON LINE A. ☐ YES ☐ NO IF YES, DATE

D. EMPLOYEE'S NAME (Last, First, M.I.) | E. SEX ☐ M ☐ F | F. DATE OF BIRTH

G. EMPLOYEE'S MAILING ADDRESS (Street, City, State, Zip) | IS THIS A CHANGE OF ADDRESS ☐ YES ☐ NO | H. EMPLOYEE'S SOC. SEC. NO.

I. MARITAL STATUS | J. NAME OF SPOUSE | SPOUSE'S DATE OF BIRTH | K. SPOUSE'S SOC. SEC. NO.

L. SPOUSE EMPLOYED - IF NO, HAS SPOUSE BEEN EMPLOYED DURING LAST 12 MONTHS ☐ YES ☐ NO ☐ YES ☐ NO | M. NAME AND ADDRESS OF SPOUSE'S EMPLOYER

N. PATIENT'S NAME | DATE OF BIRTH | O. RELATIONSHIP TO INSURED

P. IF CHILD, IS SHE/HE MARRIED ☐ YES ☐ NO | Q. IS CHILD 19 OR OLDER ☐ YES ☐ NO | IF YES, FULL-TIME STUDENT ☐ YES ☐ NO | IF YES, NAME OF SCHOOL

R. DESCRIPTION OF ACCIDENT OR ILLNESS | S. ACCIDENT OR ILLNESS DUE TO EMPLOYMENT ☐ YES ☐ NO

T. DATE OF ACCIDENT OR BEGINNING OF ILLNESS | U. INJURY DUE TO AUTO ACCIDENT ☐ YES ☐ NO | V. HAVE YOU OR YOUR DEPENDENT, OR WILL YOU OR YOUR DEPENDENT FILE A CLAIM FOR WORKERS' COMPENSATION BENEFITS ☐ YES ☐ NO

W. ARE YOU OR YOUR DEPENDENT COVERED UNDER ANOTHER GROUP INSURANCE OR GOVERNMENT PLAN SUCH AS MEDICARE, AN HMO PLAN OR AUTOMOBILE MANDATORY NO-FAULT COVERAGE WHICH WILL ALSO COVER ANY OF THE MEDICAL EXPENSES OR DISABILITY LOSSES OF THIS CLAIM ☐ YES ☐ NO IF YES, GIVE NAME OF INSURANCE COMPANY/FIRST BENEFIT INSURER, ORGANIZATION, OR HMO PROVIDING BENEFITS.
NAME & ADDRESS | POLICY NUMBER

X. **AUTHORIZATION TO RELEASE INFORMATION** - I authorize any Health Care Provider, Insurance Company, Employer, Person or Organization to release any information regarding the medical, dental, mental, alcohol or drug abuse history, treatment, or benefits payable, including disability or employment related information, to Blue Cross and Blue Shield of New Jersey, the Plan Administrator, or their authorized agents for the purpose of validating and determining benefits payable. I will receive a copy of this authorization upon request. In making this application for payment of medical bills which I claim to be a result of a job-related injury, I authorize the Plan Administrator or its authorized agent to release this information to NJ TRANSIT Rail Operations for the purpose of complying with the Federal Employer's Liability Act. This authorization or a photocopy of the original shall be valid and effective from the date of signature affixed below.

PATIENT'S SIGNATURE (Parent or Guardian if Claim is a Minor) | DATE

X. **PAYMENT AUTHORIZATION** - I authorize payment directly to those Health Care Providers described below, and/or as indicated on the enclosed bills, of Medical Benefits otherwise payable to me, for services rendered by them. | IF YES, EMPLOYEE'S SIGNATURE | DATE

X. **I certify that the foregoing information is true and correct.** | EMPLOYEE'S SIGNATURE | DATE

PHYSICIAN or PROVIDER - Complete This Section

Diagnosis or Nature of Illness or Injury - Relate diagnosis to procedures in Column D by reference to numbers 1, 2, 3, etc. or ICD-9 Code.

1.
2.
3.
4.

DATE FIRST CONSULTED FOR THIS CONDITION | HOSPITAL CONFINEMENT DATES FROM TO | DATE ABLE TO RETURN TO WORK

TOTAL DISABILITY DATES FROM TO | PARTIAL DISABILITY DATES FROM TO

NAME AND ADDRESS OF REFERRING PHYSICIAN

A. DATE OF SERVICE	B. PLACE OF SERVICE *	C. FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN (Explain unusual services or circumstances) PROCEDURE CODE (Identify:)	D. ICD-9 DIAGNOSIS CODE	E. CHARGES

YOUR PATIENT'S ACCOUNT NUMBER

PHYSICIAN'S OR PROVIDER'S TAX IDENTIFICATION NUMBER OR SOCIAL SECURITY NUMBER TO BE USED FOR TAX REPORTING.
TAX I.D. #
SOC. SEC. #

PHYSICIAN'S OR PROVIDER'S NAME AND ADDRESS
PHYSICIAN'S OR PROVIDER'S TELEPHONE NUMBER ( )

TOTAL CHARGE
AMOUNT PAID
BALANCE DUE

I certify that the foregoing information is true and correct and that the charges are the actual charges to the insured. | PHYSICAN'S OR PROVIDER'S SIGNATURE | DATE

* 1. **(IH)** - Inpatient Hospital
2. **(OH)** - Outpatient Hospital
3. **(O)** - Doctor's Office
4. **(H)** - Patient's Home
5. **(PSY)** - Day Care Facility
6. **(PSY)** - Night Care Facility
7. **(NH)** - Nursing Home
8. **(SNF)** - Skilled Nursing Facility
9. Ambulance
O. **(OL)** - Other Locations
A. **(IL)** - Independent Laboratory
B. Other Medical Facility

INSTRUCTIONS FOR FILING A CLAIM

Any person who knowingly and with intent to defraud any insurance company or other person files a statement containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act which is a crime.

1. COMPLETE EMPLOYEE INFORMATION SECTION

YOU SHOULD SUBMIT YOUR CLAIMS MONTHLY OR WHEN YOU HAVE BILLS TOTALING MORE THAN $200.00; BUT YOU MUST USE A SEPARATE CLAIM FORM FOR EACH MEMBER OF THE FAMILY.

- **IMPORTANT** - A Completed claim form must be included with each submission for each member of the family for each separate accident or illness.
- **IMPORTANT** - Be certain your social security number appears on the claim form (Employee Section, Block H).
- If you wish your benefits paid directly to the physician or provider of service, sign the special block provided (Employee Section, Block Y). Benefits will be paid directly to the hospital for a hospital confinement.
- **IMPORTANT** - You must sign and date your claim form (Employee Section, Block Z).

2. ATTENDING PHYSICIAN OR PROVIDER INFORMATION SECTION SHOULD BE COMPLETED FOR ...

- Surgery
- Doctor's Visits
- Mental Illness Expenses
- Hospital Confinement

Be certain to include procedure code and ICD-9 diagnosis code (Physician or Provider Section, Blocks C and D).

3. IF ATTACHING ITEMIZED BILLS, THEY MUST INCLUDE:

ALL BILLS

Employee Name
Patient Name
Type of Service
Date of Service
Diagnosis
Charge for Service
IMPORTANT - Be certain to include Physician or Provider Tax Identification Number

DRUG BILLS

Patient Name
Physician Name
Prescription Number
Prescription Date
Drug Name
Charge

- Make **COPIES** of bills submitted - bills will not be returned to you.
- Receipts and cancelled checks are not acceptable.

4. ADDITIONAL INFORMATION

Save your Explanation of Benefits - duplicate vouchers are not available.

Second Opinion Surgical Program - Call your Benefits Counselor for details.

5. MAILING INSTRUCTIONS.

Send your completed claim form and itemized bills to the address indicated below.

Blue Cross and Blue Shield of New Jersey
Agent for: New Jersey Transit Employees Health Benefit Program

WL- 02Y
1427 Wyckoff Road
Wall, NJ 07727