

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

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

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<sup>5. (</sup>PSY) - Day Care Facility
6. (PSY) - Night Care Facility

<sup>6. (</sup>SNF) - Skilled Nursing Facility
9. Ambulance

O. (DL) - Other Locations
 A. (IL) - Independent Laboratory
 Other Medical Facility

# INSTRUCTIONS FOR FILING A CLAIM

Any person who knowledgy 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 <u>EACH</u> 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

Diagnosis

Patient Name Type of Service Charge for Service

Date of 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

P.O. Box 127

Newark, New Jersey 07105-0127