

# **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**

<b>A. EMPLOYER</b>		<b>DATE HIRED</b>		<b>EMPLOYMENT STATUS</b> <input type="checkbox"/> HOURLY <input type="checkbox"/> SALARIED <input type="checkbox"/> RETIRED	
<b>B. PLANT LOCATION/DIVISION</b>		<b>ACCOUNT NUMBER</b>		<b>C. HAVE YOU TERMINATED EMPLOYMENT WITH EMPLOYER LISTED ON LINE A?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, DATE	
<b>D. EMPLOYEE'S NAME (Last, First, MI)</b>		<b>E. SEX</b> <input type="checkbox"/> M <input type="checkbox"/> F		<b>F. DATE OF BIRTH</b>	
<b>G. EMPLOYEE'S MAILING ADDRESS (Street, City, State, Zip)</b>				<b>H. EMPLOYEE'S SOC. SEC. NO.</b>	
<b>I. MARITAL STATUS</b>		<b>J. NAME OF SPOUSE</b>		<b>K. SPOUSE'S SOC. SEC. NO.</b>	
<b>L. SPOUSE EMPLOYED - IF NO, HAS SPOUSE BEEN EMPLOYED DURING LAST 12 MONTHS</b> <input type="checkbox"/> YES <input type="checkbox"/> NO		<b>M. NAME AND ADDRESS OF SPOUSE'S EMPLOYER</b>			
<b>N. PATIENT'S NAME</b>		<b>DATE OF BIRTH</b>		<b>O. RELATIONSHIP TO INSURED</b>	
<b>P. IF CHILD, IS SPOUSE MARRIED</b> <input type="checkbox"/> YES <input type="checkbox"/> NO		<b>Q. IS CHILD 19 OR OLDER</b> <input type="checkbox"/> YES <input type="checkbox"/> NO		<b>R. DESCRIPTION OF ACCIDENT OR ILLNESS</b>	
<b>S. DATE OF ACCIDENT OR BEGINNING OF ILLNESS</b>		<b>T. INJURY DUE TO AUTO ACCIDENT</b> <input type="checkbox"/> YES <input type="checkbox"/> NO		<b>U. HAVE YOU OR YOUR DEPENDENT, OR WILL YOU OR YOUR DEPENDENT FILE A CLAIM FOR WORKERS' COMPENSATION BENEFITS</b> <input type="checkbox"/> YES <input type="checkbox"/> NO	
<b>V. 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</b> <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE NAME OF INSURANCE COMPANY/FIRST BENEFIT INSURER, ORGANIZATION, OR HMO PROVIDING BENEFITS. NAME & ADDRESS: _____ POLICY NUMBER: _____					
<b>X. AUTHORIZATION TO RELEASE INFORMATION</b> - 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 the 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 _____					
<b>Y. PAYMENT AUTHORIZATION</b> - I authorize payment directly to those Health Care Providers described below, under as indicated on the enclosed bills, of Medical Benefits otherwise payable to me, for services rendered by them.				<b>IF YES, EMPLOYEE'S SIGNATURE</b> _____ DATE _____	
<b>Z. I certify that the foregoing information is true and correct.</b>				<b>EMPLOYEE'S SIGNATURE</b> _____ DATE _____	

## **PHYSICIAN or PROVIDER - Complete This Section**

<b>Diagnosis or Nature of Illness or Injury</b> - Provide diagnosis to procedures in Column D by reference to numbers 1, 2, 3, etc. or ICD-9 Code.		<b>DATE FIRST CONSULTED FOR THIS CONDITION</b>		<b>HOSPITAL CONFINEMENT DATES</b> FROM TO		<b>DATE ABLE TO RETURN TO WORK</b>	
<b>1.</b>		<b>TOTAL DISABILITY DATES</b> FROM TO		<b>PARTIAL DISABILITY DATES</b> FROM TO			
<b>2.</b>		<b>NAME AND ADDRESS OF REFERRING PHYSICIAN</b>					
<b>3.</b>							
<b>4.</b>							
<b>A. DATE OF SERVICE</b>	<b>B. PLACE OF SERVICE</b> ★	<b>C. FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN</b> (Explain unusual services or circumstances)				<b>D. ICD-9 DIAGNOSIS CODE</b>	<b>E. CHARGES</b>
<b>YOUR PATIENT'S ACCOUNT NUMBER</b>		<b>PHYSICIAN'S OR PROVIDER'S TAX IDENTIFICATION NUMBER OR SOCIAL SECURITY NUMBER TO BE USED FOR TAX REPORTING</b> TAX ID. #		<b>PHYSICIAN'S OR PROVIDER'S NAME AND ADDRESS</b>		<b>TOTAL CHARGE</b>	
		<b>SOC. SEC. #</b>		<b>PHYSICIAN'S OR PROVIDER'S TELEPHONE NUMBER</b>		<b>AMOUNT PAID</b>	
						<b>BALANCE DUE</b>	
<b>I certify that the foregoing information is true and correct and that the charges are for the insured.</b>				<b>PHYSICIAN'S OR PROVIDER'S SIGNATURE</b>		<b>DATE</b>	

Inpatient Hospital  
Outpatient Hospital  
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	Diagnosis
Patient Name	Charge for Service
Type of Service	<b>IMPORTANT</b> - Be certain
Date of Service	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