



Horizon Blue Cross Blue Shield of New Jersey



State Health Benefits Program (SHBP) and  
School Employees' Health Benefits Program (SEHBP)



**NJ DIRECT Claim Form**

Please Print This Form In Color (If Available).

THIS FORM CAN BE DOWNLOADED FROM OUR WEB SITE AT [www.HorizonBlue.com/SHBP](http://www.HorizonBlue.com/SHBP)

**SUBSCRIBER'S INFORMATION**

1. LAST NAME  FIRST NAME  MI

2. DATE OF BIRTH  3. SEX  4. IDENTIFICATION NUMBER

MM DD YYYY M F Prefix Number Portion

6. ADDRESS  CITY  STATE  ZIP CODE

(No., Street)

7. TELEPHONE NUMBER  8. EMPLOYER'S NAME

(Include Area Code)

9. PLAN NAME  10. DO YOU HAVE OTHER HEALTH COVERAGE? ☐ No ☐ Yes

N J D I R E C T

IF YES, COMPLETE ITEMS 20 - 26

**PATIENT'S INFORMATION** (If Patient is the same as the Subscriber, please skip to #16)

11. LAST NAME  FIRST NAME  MI

12. DATE OF BIRTH  13. SEX  14. TELEPHONE NUMBER

MM DD YYYY M F (Include Area Code)

15. ADDRESS  CITY  STATE  ZIP CODE

(No., Street)

16. RELATIONSHIP TO INSURED ☐ Self ☐ Spouse\* ☐ Child ☐ Other ☐ 17. PATIENT'S STATUS ☐ Single ☐ Married ☐ Other ☐ EMPLOYED ☐ FULL-TIME STUDENT ☐ PART-TIME STUDENT

18. IS PATIENT'S CONDITION RELATED TO:  
a. EMPLOYMENT? (Current or Previous) ☐ No ☐ Yes b. AUTO ACCIDENT? ☐ No ☐ Yes c. OTHER ACCIDENT ☐ No ☐ Yes

19. DATE OF CURRENT ILLNESS  ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

MM DD YYYY

**OTHER HEALTH COVERAGE INFORMATION**

20. LAST NAME OF SUBSCRIBER  FIRST NAME  MI

21. DATE OF BIRTH  22. SEX  23. IDENTIFICATION NUMBER

MM DD YYYY M F

24. TELEPHONE NUMBER  25. EMPLOYER'S NAME

(Include Area Code)

26. HEALTH COVERAGE PLAN NAME OR PROGRAM NAME

**AUTHORIZATION**

27. I certify that the information provided is correct and complete, and that I am claiming benefits only for charges actually incurred by the patient named. I authorize any provider who participated in care and treatment to release to Horizon Blue Cross Blue Shield of New Jersey (Horizon BCBSNJ) all medical or other information requested for the processing of this claim. I agree that New Jersey State auditors, State Health Benefits Program, School Employees' Health Benefits Program and Horizon BCBSNJ may see, or get a copy of any such medical records. This information is for the sole use of the State Health Benefits Program, School Employees' Health Benefits Program and Horizon BCBSNJ to administer and analyze the health program. Unless a law requires it, information will not be given in an identifiable form to any other persons unless I agree to its release in writing. I agree to reimburse Horizon BCBSNJ should this claim be incorrectly paid.

SIGNATURE OF PATIENT (unless a minor)

DATE

You may complete the required fields online and then save or print a copy for submission. To save a completed copy to your computer, choose File > Save As to rename the file and save the form with your information to your computer.

## PLEASE READ THIS IMPORTANT INFORMATION

WHEN YOU ARE SUBMITTING EXPENSES FOR MORE THAN ONE FAMILY MEMBER, PLEASE USE A SEPARATE CLAIM FORM FOR EACH PERSON. ITEMIZED BILLS FOR COVERED SERVICES OR SUPPLIES MUST BE ATTACHED TO THIS FORM AND INCLUDE THE FOLLOWING:

Check that each itemized bill is legible and contains ALL of the following information:

- ☒ NAME & ADDRESS of person or institution rendering the service or supplying the item
- ☒ PATIENT'S FULL NAME
- ☒ TYPE of service rendered/produced or item supplied
- ☒ DATE each service rendered or item supplied
- ☒ AMOUNT charged for each service rendered or item supplied
- ☒ DIAGNOSIS of ailment

**BILLS MISSING ANY OF  
THIS INFORMATION MAY  
BE RETURNED TO YOU**

Cash register receipts, cancelled checks, money order receipts, personal itemizations, and bills only noting a "balance due" are not acceptable.

## COORDINATION OF BENEFITS?

If you or your covered dependent(s) are covered by another health insurance program, please provide the information requested in the Other Health Coverage Section. Example: Spouse covered by another insurance company or other Horizon Blue Cross Blue Shield of New Jersey coverage.

When submitting charges for services or supplies that have been partially paid or declined by other group health coverage, attach a copy of the Notice of Payment or Explanation of Benefits from the other health care insurer along with itemized bill(s).

## MEDICARE?

If PATIENT is eligible for Medicare Benefits, be sure you include the Explanation of Medicare Benefits (EOMB) that was sent to patient explaining the charges paid or not paid by Medicare.

To process a claim for your NJ DIRECT secondary coverage, we need a copy of the EOMB. This EOMB should have been sent to you when Medicare processed your claim. If your EOMB has more than one page, send us copies of all pages. Please write your NJ DIRECT identification number clearly on the first page.

**CLAIM FORM MAY BE  
RETURNED TO YOU IF THIS  
ADDITIONAL INFORMATION  
IS NOT SUPPLIED**

## HELPFUL HINTS

When you are submitting expenses for more than one family member, please use a separate claim form for each person. It is suggested that you make copies for your own use before you submit the original bills.

Durable medical equipment? (Wheel chair, crutches, braces, oxygen, etc.) Your doctor's certification must be submitted indicating the expected length of time the equipment will be in use. If renting, please have your medical equipment supplier also indicate the purchase price of the equipment on the bill.

Foreign Claim? Bills for services incurred outside of the U.S. must include an English translation and the exchange rate at the time of services.

If you have any questions about how to submit your Claims, please call the Customer Service # 1-800-414-SHBP (7427).

## WHERE TO SUBMIT YOUR CLAIM FORMS

Please mail completed claim form for:

### MEDICAL CLAIMS TO:

Horizon Blue Cross Blue Shield of New Jersey  
P.O. Box 820  
Newark, NJ 07101-0820

### MENTAL HEALTH/SUBSTANCE ABUSE CLAIMS TO:

Horizon Blue Cross Blue Shield of New Jersey  
Horizon Behavioral Health  
P.O. Box 10191  
Newark, NJ 07101-3189

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### FRAUD WARNING

ANY PERSON WHO KNOWINGLY FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE OR MISLEADING INFORMATION IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES  
TO REPORT SUSPECTED FRAUD CALL 1-800-624-2048 AT HORIZON BLUE CROSS BLUE SHIELD OF NEW JERSEY