LaBounty Family Chiropractic

BCBS Reimbursement for Insurance Benefits

LaBounty Family Chiropractic requests full payment for services received at each appointment. We accept cash, personal check, and most major credit cards. We also accept Flexible Spending Account (FSA) and Health Savings Account (HSA) cards.

If you would like to submit your visit(s) to BCBS, please follow the steps outlined in our clinic procedure listed below:

1. Upon check-out of your visit, make payment in full and request a Super Receipt. Let the front desk staff know you will be submitting to BCBS and need a claim form.

2. Staff will provide you with a Super Receipt for the current visit and a BCBS Claim form, pre-filled with the clinic and doctor specific information in Section 2.

3. When you are ready to submit the claim(s) to your insurance, you will fill out the highlighted areas on the BCBS claim form and mail it to the P.O. box listed.

4. You will receive reimbursement paid & mailed directly to you, according to the policies and procedures of your BCBS policy.

LaBounty Family Chiropractic

Super Receipt EXAMPLE

[redacted]
[redacted]NW[redacted]Dr. #[redacted]
Ankeny IA 50023

CASH PATIENT
1310 SW State Street
Ankeny IA 50023

Clinic Name and Address	
LaBounty Family Chiropractic **1310 SW State Street Suite B** **Ankeny IA 50023-2550** **(515) 965-8280**	
Patient	**Case: Chiro Care 11/22/17**
[redacted] [redacted]NW[redacted]Dr. #[redacted] Ankeny IA 50023 **ID #:** CASH PATIENT **Rel to Insured:** Self	**DOB:** 12/[redacted] **Sex:** Male
Insured	
[redacted] [redacted]NW[redacted]Dr. #[redacted] Ankeny IA 50023 **DOB:** 12/[redacted]	**Sex:** Male

4/3/2018 to 4/3/2018

Date of Service	Provider Info Diagnosis CPT Description	Charges	Write Offs	Patient Payments
4/3/2018	LaBounty, Michael **NPI#** 1922178946 **Tax ID#** 371526466 [M99.03] Segmental and somatic dysfunction of lumbar region, [M51.26] Other intervertebral disc displacement, lumbar region, [M99.02] Segmental and somatic dysfunction of thoracic, [M51.24] 'Other intervertebral disc displacement, thoracic region'			
	[98940] Adjustment, 1-2 regions	$50.00	$0.00	$50.00
	[99213] Established Patient exam	$60.00	$0.00	$60.00
	[73564] X-ray, knee, complete, minimum 4 views	$80.00	$0.00	$80.00
	[72082] X-Ray Entire Spine, Progress	$120.00	$0.00	$0.00
	[73030] X-ray, shoulder, minimum of 2 views	$80.00	$0.00	$45.00
Totals		$390.00	$0.00	$235.00

Member Submitted Claim Form

Thank you for being a member of Wellmark Blue Cross and Blue Shield. Please review the instructions below for helpful information on how to submit your claim so it processes quickly and accurately. **Note:** *All fields on this form are required in order to be processed correctly. Incomplete claim forms will not be processed. Complete the form using a blue or black pen. Please do not use highlighters.*

This claim form is for health care services received inside the United States. If services were provided outside the U.S., please use the Blue Cross and Blue Shield Global™ Claim Form. For prescription drugs, please use the Prescription Reimbursement Claim Form.

Member Instructions - Section 1

1. Complete section 1 and sign the form. Ask your physician or health care provider to complete section 2.
2. Submit a separate claim form for each family member and each provider of health care service. Retain copies of all documents for your records.
3. Submit completed form (section 1 and 2) and any receipts and itemized statements to: Wellmark Blue Cross and Blue Shield - Mail Station 1E238 - PO Box 9291 - Des Moines, IA 50306-9291

Please file your claim as soon as possible after receiving care. For specific filing deadlines refer to the Claims section of your Wellmark Coverage Manual for more details. If you have questions or need assistance go to Wellmark.com or call Customer Service at the phone number shown on the back of your Wellmark ID card.

Physician/Provider Instructions - Section 2

1. Complete section 2 and sign form.
2. Return completed form to the policy holder/patient or mail it to the address listed above on the patient's behalf.

Section 1 - Member

ID Card Information

Policyholder's Identification Number on ID Card: (include any letters)

___ _____

Policyholder's Name on ID Card: (first name, middle initial, last name)

Policyholder's Date of Birth: _____/_____/_____

Policyholder's Address:

Patient Information (if different from Policyholder)

Patient First Name:

Patient Last Name:

Patient's Date of Birth: _____/_____/_____

Patient's Relationship to Policyholder:
☐ Self ☐ Spouse ☐ Child ☐ Other

Patient's Address: (if different from Policyholder)

I certify that the information given is complete and correct, and that I am claiming benefits only for charges incurred by the patient named above.
Policy/Certificate Holder's Signature: _____ Date: _____/_____/_____

Section 2 - Provider

Services and Provider of Service Information - To be filled out by the Provider

For services related to hospitalization or long-term care facility please provide the following:
Admission Date: _____/_____/_____ Discharge Date: _____/_____/_____

From Date of Service MM/DD/YYYY	To Date of Service MM/DD/YYYY	HCPCS/CPT/ADA Code including Modifier	Description of Service/Supply	Diagnosis Code	Charges	Days or Units
		←	See attached Super Receipt	→	$	
					$	
					$	
					$	
					$	
				Total amount billed/charged:	$	
				Amount paid by member:	$	

Provider of Service Name:	Tax ID:	Billing NPI:
LaBounty Family Chiropractic	37-1526466	1457466328
Address (location where services were provided):	**City, State and ZIP:**	**Place of Service:**
1310 SW State Street, Ste B	Ankeny, IA 50023	☐ Inpatient ☐ Outpatient ☑ Office ☐ Other _____
Referring/Rendering Provider Name:	**Referring/Rendering Provider NPI:**	
Dr. <first name> <last name>	<10 digit Dr. specific>	

I certify these services were performed by me or in my presence under my supervision.

Provider of Service Signature: <signature of servicing Dr.> Date: _____

C-2318978 5/17 AN-T