Attached are a couple of slides from our town hall meeting with the information to file claims with BCBS of Texas. Additionally, here a list of questions you can ask BCBS in regards to your out of network benefits. Included is a link for the claim form.
Feel free to contact us with any questions.

Questions to ask member services for out of network benefits:

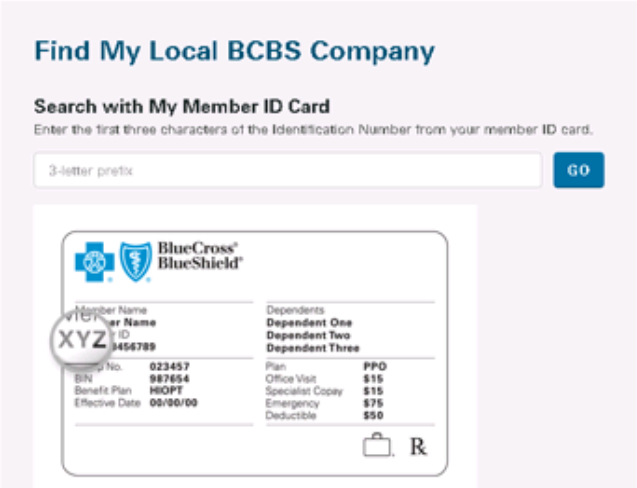
1. Do I have out of network benefits?
    a. If the answer in no, then ask if there is any way you could get reimbursed for services performed outside of the network (sometimes there might be exceptions).
    b. If the answer is yes to the question about out of network benefits, proceed with the following questions.
2. I would like get information about my coverage for out of network chiropractic services done in the office. Would you be able to help?
3. Is there a deductible to meet? If so, what is the deductible?
4. After I meet my deductible, is there a co-insurance?
5. Does my in-network deductible also apply to my out of network deductible?
6. Do I have an out of network out of pocket(OOP)?
7. Is this combined with my in-network OOP?
8. What is the reasonable and customary rate for my chiropractic services?
    a. They will probably need the following:
        i. TAX ID, NPI, CPT codes and ICD 10 codes.
    b. The specific information can be found on your services rendered receipt as well.
    c. Members services might also have this information from previous claims.
9. Is there a visit limit?
10. Are my visit limits based on medical necessity?
11. Are there any other limitations to chiropractic services?
12. How do I file a claim?
13. Is there a time limit for filing claims?
14. How soon can I expect a payment or explanation of benefits?

https://www.bcbstx.com/pdf/forms/medical_claim_tx.pdf

https://www.bcbs.com/member-services

Out of Network Claims BCBS

- If you have an out of state BCBS plan and don't have an existing account with BCBS, search for bcbsmemberservice.
- Then enter your BCBS member ID prefix.
- This will redirect you to the appropriate area for claims.

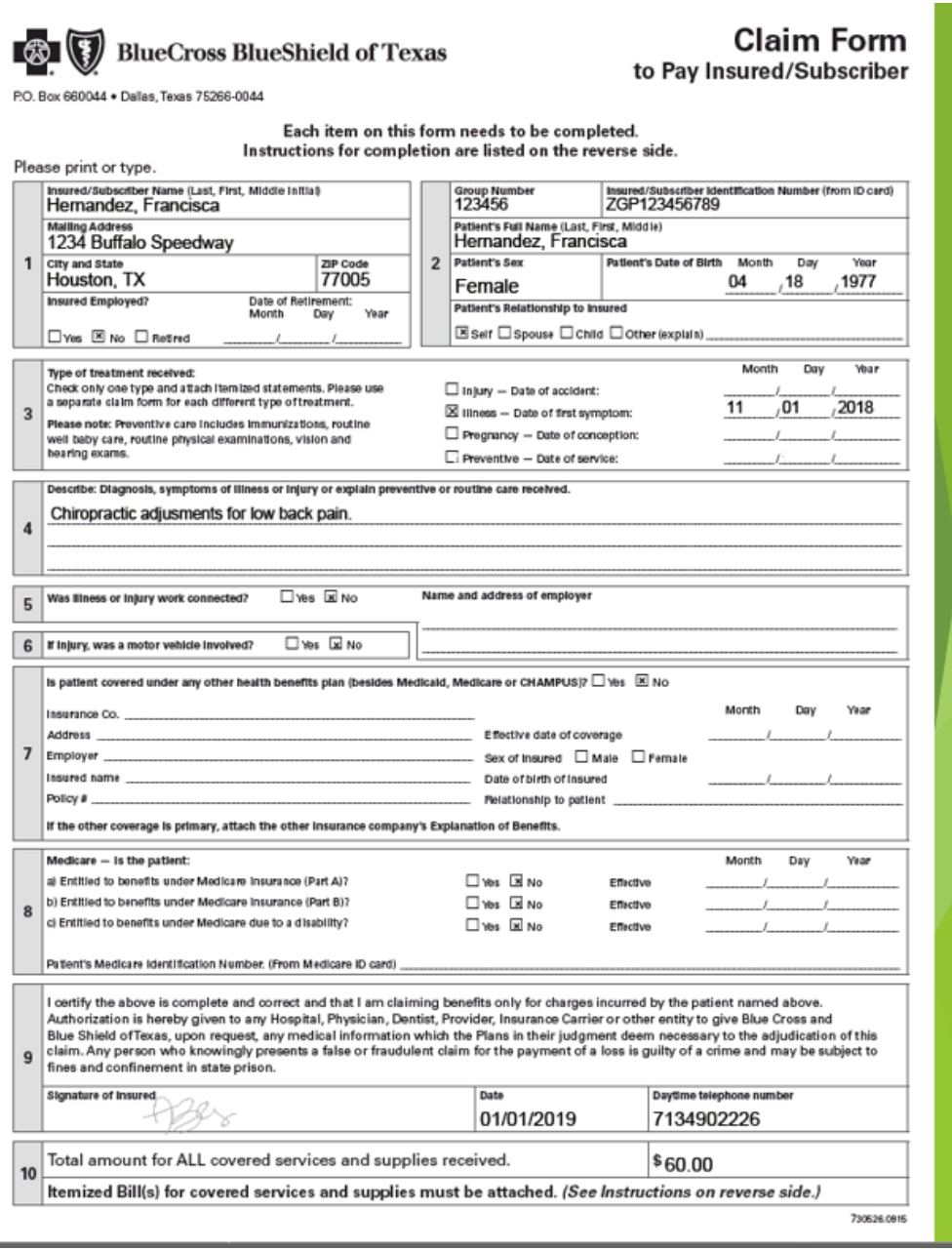


- For Texas BCBS members there is a link that will bring you directly to the claim form.

https://www.bcbstx.com/pdf/forms/medical_claim_tx.pdf

Out of Network Claims BCBS

- The second page is your claim form.
- The top section is your information. Fill in your Member ID, Group number, Birthdate, Gender, Patient, and Policyholder information.
- Choose Illness, unless you've been in an accident. Enter your date of first symptom.
- Fill in a description of your treatment.
- The accident information only needs to be filled out if you've been in an accident.
- The other insurance information only needs to be filled out if you have other coverage.
- Be sure to sign and date your form.
- Fill in the total amount for services received.
- Send this form along with the Services Rendered Statement we give you.



BlueCross BlueShield of Texas

P.O. Box 660044 • Dallas, Texas 75266-0044

Claim Form
to Pay Insured/Subscriber

Each item on this form needs to be completed.
Instructions for completion are listed on the reverse side.

Please print or type.

1 Insured/Subscriber Name (Last, First, Middle Initial): Hernandez, Francisca
Mailing Address: 1234 Buffalo Speedway
City and State: Houston, TX
ZIP Code: 77005
Insured Employed? ☐ Yes ☒ No ☐ Retired
Date of Retirement: Month Day Year

2 Group Number: 123456
Insured/Subscriber Identification Number (from ID card): ZGP123456789
Patient's Full Name (Last, First, Middle): Hernandez, Francisca
Patient's Sex: Female
Patient's Date of Birth: Month 04 Day 18 Year 1977
Patient's Relationship to Insured: ☒ Self ☐ Spouse ☐ Child ☐ Other (explain)

3 Type of treatment received:
Check only one type and attach itemized statements. Please use a separate claim form for each different type of treatment.
Please note: Preventive care includes immunizations, routine well baby care, routine physical examinations, vision and hearing exams.
☐ Injury — Date of accident:
☒ Illness — Date of first symptom: 11 / 01 / 2018
☐ Pregnancy — Date of conception:
☐ Preventive — Date of service:

4 Describe: Diagnosis, symptoms of illness or injury or explain preventive or routine care received.
Chiropractic adjusments for low back pain.

5 Was illness or injury work connected? ☐ Yes ☒ No
Name and address of employer

6 If injury, was a motor vehicle involved? ☐ Yes ☒ No

7 Is patient covered under any other health benefits plan (besides Medicaid, Medicare or CHAMPUS)? ☐ Yes ☒ No
Insurance Co.
Address
Employer
Insured name
Policy #
Effective date of coverage
Sex of Insured ☐ Male ☐ Female
Date of birth of Insured
Relationship to patient
If the other coverage is primary, attach the other insurance company's Explanation of Benefits.

8 Medicare — Is the patient:
a) Entitled to benefits under Medicare Insurance (Part A)? ☐ Yes ☒ No Effective
b) Entitled to benefits under Medicare Insurance (Part B)? ☐ Yes ☒ No Effective
c) Entitled to benefits under Medicare due to a disability? ☐ Yes ☒ No Effective
Patient's Medicare Identification Number. (From Medicare ID card)

9 I certify the above is complete and correct and that I am claiming benefits only for charges incurred by the patient named above. Authorization is hereby given to any Hospital, Physician, Dentist, Provider, Insurance Carrier or other entity to give Blue Cross and Blue Shield of Texas, upon request, any medical information which the Plans in their judgment deem necessary to the adjudication of this claim. Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.
Signature of Insured
Date: 01/01/2019
Daytime telephone number: 7134902226

10 Total amount for ALL covered services and supplies received. $60.00
Itemized Bill(s) for covered services and supplies must be attached. *(See Instructions on reverse side.)*

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