Reset Form

Horizon Blue Cross Blue Shield of New Jersey
P.O. Box 1609
Newark, NJ 07101-1609

DEDUCTIBLE CARRY OVER CREDIT REPORT
(for current calendar year only)

PRODUCT:
☐ Horizon HMO
☐ Horizon POS
☐ Horizon PPO
☐ Other: ______________

You may complete the required fields below 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.

SUBSCRIBER INFORMATION

SUBSCRIBER'S LAST NAME	FIRST NAME	INITIAL		
ADDRESS STREET	CITY	STATE	ZIP	
SUBSCRIBER'S ID NUMBER	SUBSCRIBER DATE OF BIRTH	MONTH	DAY	YEAR
SUBSCRIBER'S GROUP NAME (EMPLOYER)	GROUP NUMBER			

DEPENDENT(S) INFORMATION

LAST NAME	FIRST NAME	SS#	DATE OF BIRTH	MONTH	DAY	YEAR

Check Dependent's Relationship To Subscriber
☐ HUSBAND ☐ SON ☐ OTHER
☐ WIFE ☐ DAUGHTER

AMOUNT APPLIED TO DEDUCTIBLE WITH PRIOR CARRIER ____________________

ATTACH COPY OF PRIOR CARRIER'S STATEMENT OF PAYMENT FORM

LAST NAME	FIRST NAME	SS#	DATE OF BIRTH	MONTH	DAY	YEAR

Check Dependent's Relationship To Subscriber
☐ HUSBAND ☐ SON ☐ OTHER
☐ WIFE ☐ DAUGHTER

AMOUNT APPLIED TO DEDUCTIBLE WITH PRIOR CARRIER ____________________

ATTACH COPY OF PRIOR CARRIER'S STATEMENT OF PAYMENT FORM

LAST NAME	FIRST NAME	SS#	DATE OF BIRTH	MONTH	DAY	YEAR

Check Dependent's Relationship To Subscriber
☐ HUSBAND ☐ SON ☐ OTHER
☐ WIFE ☐ DAUGHTER

AMOUNT APPLIED TO DEDUCTIBLE WITH PRIOR CARRIER ____________________

ATTACH COPY OF PRIOR CARRIER'S STATEMENT OF PAYMENT FORM

For Horizon HMO & Horizon POS Members: Deductible carry over applies only to those services which are covered under the supplemental portion of your contract and to all out of network services for Horizon POS.

Independent Licensee of the Blue Cross and Blue Shield Association
Horizon HMO is issued by Horizon Healthcare of New Jersey, a subsidiary of Horizon Blue Cross Blue Shield of New Jersey

7239 (E0301)

DEPENDENT(S) INFORMATION (Continued)

LAST NAME	FIRST NAME	SS#	DATE OF BIRTH	MONTH	DAY	YEAR

Check Dependent's Relationship To Subscriber

☐ HUSBAND ☐ SON ☐ OTHER
☐ WIFE ☐ DAUGHTER

AMOUNT APPLIED TO DEDUCTIBLE WITH PRIOR CARRIER ______________________

ATTACH COPY OF PRIOR CARRIER'S STATEMENT OF PAYMENT FORM

LAST NAME	FIRST NAME	SS#	DATE OF BIRTH	MONTH	DAY	YEAR

Check Dependent's Relationship To Subscriber

☐ HUSBAND ☐ SON ☐ OTHER
☐ WIFE ☐ DAUGHTER

AMOUNT APPLIED TO DEDUCTIBLE WITH PRIOR CARRIER ______________________

ATTACH COPY OF PRIOR CARRIER'S STATEMENT OF PAYMENT FORM

LAST NAME	FIRST NAME	SS#	DATE OF BIRTH	MONTH	DAY	YEAR

Check Dependent's Relationship To Subscriber

☐ HUSBAND ☐ SON ☐ OTHER
☐ WIFE ☐ DAUGHTER

AMOUNT APPLIED TO DEDUCTIBLE WITH PRIOR CARRIER ______________________

ATTACH COPY OF PRIOR CARRIER'S STATEMENT OF PAYMENT FORM

LAST NAME	FIRST NAME	SS#	DATE OF BIRTH	MONTH	DAY	YEAR

Check Dependent's Relationship To Subscriber

☐ HUSBAND ☐ SON ☐ OTHER
☐ WIFE ☐ DAUGHTER

AMOUNT APPLIED TO DEDUCTIBLE WITH PRIOR CARRIER ______________________

ATTACH COPY OF PRIOR CARRIER'S STATEMENT OF PAYMENT FORM

LAST NAME	FIRST NAME	SS#	DATE OF BIRTH	MONTH	DAY	YEAR

Check Dependent's Relationship To Subscriber

☐ HUSBAND ☐ SON ☐ OTHER
☐ WIFE ☐ DAUGHTER

AMOUNT APPLIED TO DEDUCTIBLE WITH PRIOR CARRIER ______________________

ATTACH COPY OF PRIOR CARRIER'S STATEMENT OF PAYMENT FORM

LAST NAME	FIRST NAME	SS#	DATE OF BIRTH	MONTH	DAY	YEAR

Check Dependent's Relationship To Subscriber

☐ HUSBAND ☐ SON ☐ OTHER
☐ WIFE ☐ DAUGHTER

AMOUNT APPLIED TO DEDUCTIBLE WITH PRIOR CARRIER ______________________

ATTACH COPY OF PRIOR CARRIER'S STATEMENT OF PAYMENT FORM