# **Member Claim Form**

Do not file prescription drugs on this form. Type or use blue or black ink to complete.

 Visit BlueCrossNC.com for prescription drug, dental and international claim forms, or call the toll-free number on your ID card.

## Filing Requirements:

- Complete a separate claim form for each covered family member.
- Enclose itemized receipts and make copies for your records. Procedure codes and diagnosis codes are required. Please obtain codes from your provider. See Section IV for required information.
- Do not file a claim if the provider is filing for the same services.
- Attach Explanation of Benefits if these services are covered by another insurance policy.
- · Claims must be filed within 18 months from the date services were received, or they will be denied.
- · Please see Section VI for mailing information.

Any claim filed without the required documentation listed above will be returned.

SECTION I: Patient Information Please enter the subscriber number from your ID card.								
Subscriber Begin with Number:					ts following (see ID card)	nember's		
Patient's Last Name:		First Na	First Name:			Middle Initial:		
Date of Birth:	Sex:	Male Balatianahin		Self Child Spouse Other:				
	'							
SECTION II: Mailing Information	☐ Please chec	k here if a	ddress has chang	ed.				
Subscriber Name:								
Address (Line 1):								
Address (Line 2):								
City:			State:	Zip (	Code:			
	_							
SECTION III: Other Insurance Information  Please complete the information below if the patient is covered by another health insurance policy.								
	ner health insurance mpany name:							
Other policy number:		Other policy holder's name:						
Other policy holder's employer name:								
Please complete the information below if the patient is covered by Medicare:								
Medicare health insurance claim number:				ls patient eligible for:	Part A Part B	Part A and B		

**PLEASE NOTE:** If your other insurance or Medicare policy is primary, you must attach a copy of the Explanation of Benefits from that insurer. Your claim cannot be processed without this information.

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## SECTION IV: Services and Supplies To Be Considered For Reimbursement

These may include ambulance services, medical appliances, diabetic supplies, glasses and/or contact lenses or out-of-network services.

Blue Cross NC requires that procedure codes and diagnosis codes be supplied by the providers of the service. Claims or itemized receipts received without the information below will be RETURNED.

Please indicate v	where services were rendered if not in North Carolina:_		
Country: Currency Used:			
Date of Service (MM-DD-YY)	Procedure Codes and Description of Service/Supplies	Diagnosis Codes and Symptoms you sought treatment for	Charge
	EVAMBLE.		

ountry				
Date of Service (MM-DD-YY)	Procedure Codes and Description of Service/Supplies	Diagnosis Codes and Symptoms you sought treatment for	Charge	
01-05-18	99201 Office or other outpatient visit for New Patient	J09 Influenza	110.00	

SECTION V: Private Duty Nursing Enclose a copy of your receipts for these services.					
Date of Service (MM-DD-YY)	Name of Nurse	Indicate RN, LPN or CNA	License Number	Hours Worked	Charge
01-05-18	EXAMPLE: Ms. Jane M. Doe	LPN	123456	8	160.00

# **SECTION VI: Mailing Information**

MAIL THIS FORM, ITEMIZED RECEIPTS AND EXPLANATION OF BENEFITS (if applicable) TO:

Blue Cross and Blue Shield of North Carolina P.O. Box 35 Durham, NC 27702

## **DID YOU REMEMBER TO:**

- Use blue or black ink to complete the form?
- Attach the Explanation of Benefits, if applicable?
- Attach itemized receipts?
- Provide your signature below?
- · Keep a copy of this form and your receipts?

I certify that the information on this form is correct and the expenses incurred were necessary for the services filed.			
Signature:	Date:	Daytime Phone Number:	