

Member Claim Form Requirements

Please note the below filing requirements and tips for filling out the attached Member Claim Form. Do not file prescription drugs or dental claims with this form.

Visit [BlueCrossNC.com/Claims](https://www.bluecrossnc.com/claims) for prescription drug, dental and international claim forms, or call the toll-free number on your ID card.

Important Notes When Completing the Claim Form:

- Type or use blue or black ink to complete.
- Complete a separate claim form for each covered family member.
- Complete a separate claim form for each provider.
- Attached receipts must include procedure codes and diagnosis codes, such as CPT/Dx code as well as tax ID and individual cost for each service/name of the provider as well as the provider's address.
- Do not file a claim if the provider is filing for the same services or if the provider is in-network.
- 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.
- If your address has recently changed, please contact Customer Service using the phone number located on the back of your ID card to ensure our records are accurate.
- Keep a copy of this form and your receipts.
- Remember to sign and date at the bottom of Section 5.

Please note: Claim form will be returned to member if provider receipts are not attached with the form!

Member Claim Form

SECTION 1: Patient Information				Please enter the subscriber number from your ID card.											
Subscriber Number:	Begin with letter prefix	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/>												2 digits following member's name <small>(see ID card)</small>	
Patient's Last Name: _____				First Name: _____				Middle Initial: _____							
Date of Birth: <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>				Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female		Relationship to Subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Child <input type="checkbox"/> Spouse <input type="checkbox"/> Other: _____									

SECTION 2: Mailing Information	
Subscriber Name: _____	
Address (Line 1): _____	
City: <input type="text"/>	State: <input type="text"/> <input type="text"/> Zip Code: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

SECTION 3: Other Insurance Information Please complete the information below if the patient is covered by another health insurance policy.			
Does the patient have other insurance?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other health insurance company 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: _____	<div style="display: flex; justify-content: space-between; align-items: flex-start;"> <div> Is patient eligible for: (check all that apply) </div> <div style="display: flex; gap: 10px;"> <div> <input type="checkbox"/> Part A <input type="checkbox"/> Part B </div> <div> <input type="checkbox"/> Part C </div> </div> </div>		

SECTION 4: International Information Please complete the information below if the provider or services rendered were out of the United States.	
Country: _____	Currency Used: _____

SECTION 5: Submitting Form Information

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

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

FAX: 1-866-990-1385

EMAIL: MemberClaimsSubmission@bcbsnc.com

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.

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:** _____