PREMERA BLUE CROSS

P.O. Box 91059
Seattle, WA 98111-9159

Member Submitted Claim Form

This form is to be used for **medical**, **vision** and **dental claims** where you incurred expenses from a provider who did not bill the plan directly.

Do not use this form for prescription reimbursement. Please use the Prescription Drug Reimbursement Form (for primary prescription claim submission) or the Secondary Insurance Prescription Drug Claim Form.

See instructions on other side for additional information to complete your claim.

1. PATIENT / MEMBER

Prefix and ID number (see ID card)	Group number (see ID card)	Patient name (first, middle, last)		Date of birth (month/day/year)
Address		**City**	**State**	**ZIP**
Home phone number	**Work or alternate phone number**	**Subscriber name** (first, middle, last)		

Does the patient have coverage from any other health plan?

☐ No, skip to section 2 ☐ Yes, please attach the Explanation of Benefits (EOB) statement from the primary plan with this claim, and complete the following information.

Name of other health plan	ID number or policy number of other health plan	Phone number of other health plan

2. CLAIM DETAILS

NOTE: You must submit an itemized bill or your claim will be returned.

Have the charges been paid in full?	Is this expense pregnancy-related?
☐ No ☐ Yes, please attach proof of payment in full with your itemized bill.	☐ No ☐ Yes, please indicate date of conception:
Have you been treated for this condition before?	**What was the exact date the condition started?**
☐ No ☐ Yes, please list dates treated:	

In what setting were these services performed?

☐ Inpatient hospital ☐ Outpatient hospital ☐ Office/clinic ☐ Surgery center ☐ Skilled nursing facility ☐ Home ☐ Other: _____

3. INTERNATIONAL CLAIM

NOTE: You must submit an itemized bill or your claim will be returned.

Is this claim for expenses incurred outside the U.S.A.?

☐ No, skip to section 4 ☐ Yes, please attach an itemized bill, available medical records, and complete this section.

Name of provider	Type of provider	Country of service	City of service	Date of service
	☐ Hospital ☐ Lab ☐ Office ☐ X-ray			

Diagnosis (describe illness and symptoms requiring treatment)	Charges	Currency used

4. ACCIDENT / INJURY

Is this claim due to an accidental injury?	Date of accident	Where did the accident occur?
☐ No, skip to section 5 ☐ Yes, complete this section		☐ Home ☐ Work ☐ School ☐ Auto ☐ Other: _____

How did the accident happen?

Description of injury

5. SIGNATURE

To be accepted, this form must be fully completed (as appropriate to the claim being submitted), signed, and have itemized bill attached.

Mail to: Premera Blue Cross, P.O. Box 91059, Seattle, WA 98111-9159

Patient signature (or legal guardian if patient cannot legally consent to services)	Relationship to patient	Date (month/day/year)
	☐ Self ☐ Other: _____	

Please note: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

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INSTRUCTIONS

A. **Complete a claim form.** Most providers will bill directly for you and no claim form will be necessary. However, if you do incur expenses from a provider who will not bill the plan directly, you will need to complete a claim form and provide an itemized bill. (See "B" for more information about itemized bills.)

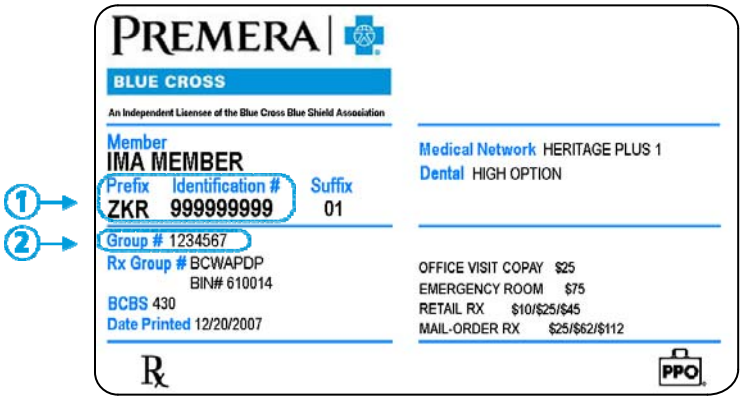
B. **Attach the itemized bill.** Please do not highlight or modify the itemized bill as this may cause delayed processing of your claim.

The itemized bill must contain all of the following information:

- Name of the member who incurred the expense
- Name, address and IRS tax identification number of the provider
- Diagnosis code (ICD-9). This information must be obtained from your provider.
- Procedure codes (CPT-4, HCPCS, ADA or UB-04). This information must be obtained from your provider.
- Date of service and itemized charge for each service rendered

Please note: Your claim will be returned if all of the information required above is not included.

C. **The front of your member ID card** may not match the card pictured below. This sample card is meant to be a guide to help you identify your prefix, identification and group numbers. These numbers are required to complete your claim form.



1 — Prefix and Identification # help us verify your eligibility, determine your coverage and process claims.

2 — Group # identifies your plan's benefits.

D. **The back of your member ID card** provides additional information. To help ensure your claims are paid properly, encourage physicians and other providers to copy the front and back of your card each time you visit.

You can research claim and eligibility information online. Visit our self-service Web site at *premera.com*. You may also call Customer Service at the phone number shown on the back of your ID card.