BlueCross BlueShield
BluePlus
of Minnesota

Independent licensees of the Blue Cross and Blue Shield Association

SUBSCRIBER CLAIM FORM

P.O. Box 64338
St. Paul, Minnesota 55164-0338

COPY FROM BLUE CROSS AND BLUE SHIELD OF MINNESOTA ID CARD

DO NOT COMPLETE SHADED AREAS

1-2

01

IDENTIFICATION NUMBER (15–27) | GROUP NUMBER (28–34)

SUBSCRIBER'S LAST NAME (25–52) | FIRST NAME (53–64) | INIT. (65) | (66)

02

PATIENT'S LAST NAME (15–32) | FIRST NAME (33–44) | INIT. (45) | PATIENT'S BIRTHDATE MO. DAY YR. (46–51)

PATIENT'S SEX: ☐ (1) MALE ☐ (2) FEMALE (52) | PATIENT'S RELATIONSHIP TO SUBSCRIBER: ☐ (1) SELF ☐ (2) SPOUSE ☐ (3) DEPENDENT (Not Spouse) (53) | (54) IS CONDITION JOB RELATED? ☐ (1) YES ☐ (2) NO ☐ (3) W

03

SUBSCRIBER'S ADDRESS, STREET (15–40) | CITY (41–61) | STATE (62–63) | ZIP CODE (64–68)

04

IS THIS SERVICE RELATED TO: ☐ (1) ILLNESS ☐ (2) INJURY ☐ (3) MATERNITY ☐ (4) AUTO ACCIDENT (15) | MO. DAY YR. (21)

IF ILLNESS, DATE OF FIRST SYMPTOM
IF INJURY, DATE OF ACCIDENT IS REQUIRED
IF MATERNITY, DATE OF LAST MENSTRUAL PERIOD

IF HOSPITALIZED: ADMISSION DATE MO. (33) DAY YR. (38) | DISCHARGE DATE MO. (39) DAY YR. (44) | NAME OF FACILITY | NAME OF ADMITTING PHYSICIAN

SYMPTOMS AND/OR DIAGNOSIS

Name of doctor or other health care professional providing service _____

Address _____

OTHER COVERAGE?

Does patient have other insurance coverage ☐ No ☐ Yes If Yes, indicate identification number and name and address of other insurance carrier.

IDENTIFICATION NUMBER _____ NAME _____ ADDRESS _____

Was this service related to an automobile accident or work-related accident? ☐ Yes ☐ No If yes, please provide the name and address of the auto insurance or workers' compensation carrier.

NAME _____ ADDRESS _____

MEDICARE? Medicare HIC # _____

Is patient eligible for Part A Medicare Hospital Insurance? ☐ Yes ☐ No.

Is patient eligible for Part B Medicare Hospital Insurance? ☐ Yes ☐ No If Yes, you must also include a copy of your Explanation of Medicare Benefits form with the itemized bill.

The information given above is true and correct to the best of my knowledge. **A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.**

Signature _____ Date Signed _____

Telephone Number Home: _____ Office: _____

IMPORTANT, PLEASE READ THE FOLLOWING: Claims must be submitted within 15 months of the date of service.

HOW TO SUBMIT YOUR CLAIM:

1. Complete a separate Subscriber Claim Form for each patient and for each doctor or other medical provider. Please answer all questions to get the fastest claims service.
2. Attach a copy of the **itemized bill** from the doctor's office. The bill should show:
   - the doctor's name and address
   - the diagnosis or symptoms of illness
   - the date, place and type of service
   - the charge for each service
3. **For Medicare patients only:** In addition to your itemized bill, attach a copy of your Explanation of Medicare Benefits form.

NOTE: We cannot return your claim or materials you send with it. Please make copies for your personal files.