BlueCross BlueShield of North Carolina

MEMBER CLAIM FORM

Do not file for prescription drugs on this form.

TIPS FOR FILING:

- Claims must be filed within 18 months from the date services were received or they will be denied for late filing.
- Complete a separate claim form for each covered family member.
- Type or print legibly.
- Enclose receipts and make copies for your records.
- **Do not file prescription drugs on this form. See the back of the form for filing information.**
- Do not file a claim if the Provider or Hospital is filing for the same services.
- Attach Explanation of Benefits if these services are covered by another group health policy.
- Mailing instructions are included on the back of this form.

SECTION I: PATIENT INFORMATION

SUBSCRIBER NUMBER

BEGIN WITH 3 ALPHA PREFIX

2 DIGITS PRECEDING PATIENT'S NAME (Please see ID Card)

PATIENT LAST NAME | FIRST NAME | MI

PATIENT DATE OF BIRTH

PATIENT SEX

☐ MALE ☐ FEMALE

PATIENT RELATIONSHIP TO SUBSCRIBER

☐ SELF ☐ CHILD ☐ SPOUSE ☐ OTHER _____

SECTION II: SUBSCRIBER INFORMATION

SUBSCRIBER NAME

ADDRESS *(LINE 1)*

ADDRESS *(LINE 2)*

CITY | STATE | ZIP CODE

☐ ***PLEASE CHECK HERE IF ADDRESS HAS CHANGED***

SECTION III: OTHER INSURANCE INFORMATION

PLEASE COMPLETE THE INFORMATION BELOW IF THE PATIENT IS COVERED BY ANOTHER GROUP HEALTH INSURANCE.

Does the patient have other insurance? ☐ Yes ☐ 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

IS PATIENT ELIGIBLE FOR:

☐ PART A ☐ PART B ☐ PART A AND B

PLEASE NOTE: IF YOUR OTHER INSURANCE OR MEDICARE POLICY IS PRIMARY, PLEASE ATTACH A COPY OF THE EXPLANATION OF BENEFITS. 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.

SUBSCRIBER SIGNATURE | DATE | TELEPHONE NUMBER WE CAN CONTACT YOU *(IF NECESSARY)*

Please use the reverse side of this form to provide a description of services you are filing for.

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SECTION IV: OTHER SERVICES AND SUPPLIES NOT FILED BY PROVIDER OR HOSPITAL

(Attach a legible copy or original itemized receipts)

THESE MAY INCLUDE OFFICE VISITS, HOSPITAL VISITS, PHYSICAL THERAPY, DIABETIC SUPPLIES, AMBULANCE SERVICES, MEDICAL APPLIANCES, ETC.

■ If services were rendered outside the USA, please indicate: **COUNTRY:** _____ **CURRENCY USED:** _____

DATE OF SERVICE *(MM/DD/YY)*	DESCRIPTION OF SERVICE / SUPPLIES	DIAGNOSIS OR SYMPTOMS YOU SOUGHT TREATMENT FOR	CHARGE
01-05-99	EXAMPLE: Office Visit	Cold and Flu Symptoms	$54.00

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 OR LPN	LICENSE NUMBER	HOURS WORKED	CHARGE
01-05-99	EXAMPLE: Ms. Jane M. Doe	LPN	123456	8	$160.00

SECTION VI: MAILING INFORMATION

MAIL THIS FORM TO:

Blue Cross and Blue Shield of North Carolina
PO Box 35
Durham, NC 27702

If claim is for prescription drugs or insulin that are not being filed for you, please complete a prescription drug claim form and mail to:

MEDCO HEALTH SOLUTIONS
PO BOX 307
LEE'S SUMMIT, MO 64063-2187

ADDITIONAL CLAIM FORMS CAN BE PRINTED FROM OUR WEBSITE, *BCBSNC.COM*, OR REQUESTED BY CALLING CUSTOMER SERVICE AT THE TOLL FREE NUMBER ON YOUR ID CARD.