



DO NOT WRITE IN THIS SPACE OFFICE USE ONLY

SEE INSTRUCTIONS ON THE BACK OF THIS FORM. PLEASE PRINT ALL INFORMATION CLEARLY.

SUBSCRIBER INFORMATION

Identification Number, Subscriber's Last Name, First Name, Middle Initial, Address- Number and Street, City, State, Zip Code, Employer's Name

PATIENT INFORMATION (Use a separate form for each patient)

Patient's Last Name, First Name, Middle Initial, Date of Birth, Sex, Patient Is: (Check one), 1. Male, 2. Female, 3. Child, 4. Handicapped, 5. Student, 6. Stepchild, 7. Other

PATIENT ENROLLED IN: Medicare Part A, Medicare Part B, Other Blue Cross and Blue Shield membership, Other insurance plan, Identification number, Effective date, Name and address of other insurance

WAS TREATMENT FOR: 1. Accident at work, 2. Auto accident, If yes, give name of auto insurance, Policy number

CLAIM INFORMATION (Attach itemized bills to section noted below.)

Table with columns: /If claim is out-of-network, TYPE OF SERVICE, PROVIDER NAME, DIAGNOSIS, Date of Service (MO, DAY, YR), AMOUNT CHARGED, OFFICE USE ONLY

TOTAL NUMBER OF BILLS ATTACHED: TOTAL CHARGES: \$

CERTIFICATION AND AUTHORIZATION (This form must be signed and dated)

I authorize the release of any information to Blue Cross and Blue Shield about my examination and treatment. I certify that the information provided in support of this claim is complete and correct and that I have not been previously reimbursed for these services.

Subscriber's Signature: Date:

INSTRUCTIONS

File this form when you receive a bill for services for which the provider does not directly submit a claim to Blue Cross and Blue Shield of Massachusetts.

When filing a claim, please be sure to:

1. complete a separate form for each patient.
2. answer all questions on this form and complete claim checklist below.
3. attach original itemized bills which include:

Patient's name
Date(s) of service
Type(s) of service
Individual charges for each date and type of service rendered
Name and address of provider of service

Additionally, drug receipts must indicate:

Prescription number(s)
Name of drug
Quantity dispensed
Name of prescribing physician

4. include only one service on each line

NOTE: PLEASE KEEP COPIES OF YOUR BILLS PRIOR TO SENDING THE ORIGINALS WITH THIS CLAIM. SERVICES THAT ARE DENIED FOR PAYMENT WILL BE NOTED ON YOUR SUBSCRIBER CLAIM SUMMARY. WE DO NOT RETURN ANY BILLS TO YOU EVEN IF THEY ARE DENIED FOR PAYMENT.

5. attach all related "Subscriber Claim Summary" or "Explanation of Medicare Benefit" forms you may have received previously on these services.
6. sign and date the completed form,
7. MAIL THIS FORM TO:

Blue Cross and Blue Shield of Massachusetts
P.O. Box 9131
N. Quincy, MA. 02171-9131

CLAIM CHECKLIST

PLEASE REVIEW THIS CHECKLIST BEFORE SENDING YOUR CLAIM TO US.
INCOMPLETE FORMS MAY BE RETURNED TO YOU.

- Have you listed your Blue Cross and Blue Shield identification number in the space provided?
- Have you listed a diagnosis or illness on each line of the claim information section?
- Have you listed the total charges for this claim?
- Have you attached original itemized bills?
- Have you attached all related Subscriber Claim Summary or Explanation of Medicare Benefit forms you may have received previously on these services?
- Have you signed and dated the completed claim form?