Regence BlueCross BlueShield of Utah — Regence ValueCare — Regence HealthWise

Independent Licensees of the Blue Cross and Blue Shield Association

MEDICAL CLAIM FORM

DIRECTIONS: Please read and fill out entire form

1.) This form **must** be completely filled out in order to process your claim(s). **Please be thorough**.

2.) Attach all medical bill(s) relating to the claim.
   A. Make sure bills identify patient.
   B. All bills should show date of treatment, description of service, and amount of charges.
   C. All statements should have your identification number listed.

3.) Sign form and mail receipts to:

Regence BlueCross BlueShield of Utah
P. O. Box 30270
Salt Lake City, Utah 84130-0270

If you have questions or concerns, please call Customer Service at **(801) 333-2100** or **1 (800) 624-6519**
Monday — Friday, 7:30 a.m. to 6 p.m. (MST)
Fax: (801) 333-6523

EMPLOYEE (MEMBER) INFORMATION: (This is the individual whose name is on the I.D. Card)
Please Print

Employee Name: ______________________

Employee Identification Number: ______________________

Mailing Address: ______________________

____
City State ZIP Code

Employer's Name: ______________________

PATIENT INFORMATION:

Patient Name: ______________________ Sex: Male ☐ Female ☐ Date of Birth: _____/_____/_____

Claim(s) are for: Employee ☐ Spouse ☐ Child ☐

Are you, the patient or spouse covered under any other group plan, health maintenance organization, government plan or insurance policy which will also pay for any of the expenses of this claim? Yes ☐ No ☐
If Yes, give name, address and policy number of plan providing benefits

Name and Address: ______________________ Policy No: ______________________

PATIENT OR PARENT MUST SIGN BELOW: AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize any insurance company, prepayment organization, employer, hospital, or physician to release all information with respect to me or any of my dependents which may have a bearing on the benefits payable under this or any other plan providing benefits or services. I hereby certify the information provided is correct and true to the best of my knowledge.

______________________ ______________
Signature of Patient or Parent *(if patient is a minor)* Date

(Please see helpful hints to speed up your reimbursement)

HELPFUL HINTS
TO SPEED UP YOUR REIMBURSEMENT

DID YOU INCLUDE THE FOLLOWING NECESSARY INFORMATION?

✔ Cardholder ID number

ALSO ...

✔ Did you complete the entire front section of this form including:
- Your Employer's name?
- Whether your claim is for double coverage or not?
- Your correct mailing address?

FACT TO KNOW ...

✔ MEMBER REIMBURSEMENTS TAKE APPROXIMATELY **2 - 4 WEEKS** TO PROCESS.

✔ USE THIS FORM EACH TIME YOU ARE SUBMITTING CLAIM(S) FOR REIMBURSEMENT.

✔ SAVE TIME BY MAKING COPIES OF THIS FORM FOR FUTURE MEMBER REIMBURSEMENTS.

✔ CUSTOMER SERVICE HOURS OF OPERATION ARE:

7:30 a.m. — 6 p.m., MONDAY — FRIDAY (MST)

PHONE: **(801) 333-2100** or **1 (800) 624-6519**

FAX: (801) 333-6523

E-MAIL: **ut_customerservice@regence.com**