Regence

Regence BlueCross BlueShield of Utah is an Independent Licensee of the Blue Cross and Blue Shield Association

DIRECT MEMBER REIMBURSEMENT FORM

Thank you for choosing us for your health insurance coverage. Use this claim form for any reimbursement requests you may have. If you received services from a participating provider, your claim should be submitted by the provider; therefore, you do not need to submit this form unless you know that your claim was not submitted. Please complete a separate form for each family member, pharmacy, or provider (print additional copies of Pg. 2 if necessary). **For claim filing time limits, review your benefit information.**

1. Complete the information below and where indicated on the following page.
2. Write your ID number on the top of each page.
3. Tape your original receipts in the boxes marked for receipts; cash register receipts will not be accepted.
4. Retain copies of receipts for your records. Receipts will not be returned.
5. Sign the completed form where indicated at the bottom of this page, and mail to:

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

MEMBER INFORMATION		
Patient's Name (Last, First, M.I.)	**Patient's Date of Birth**	**Patient's Sex** ☐ **Male** ☐ **Female**
Policyholder's Name (Last, First, M.I.)	**Patient's Relationship to Policyholder** ☐ **Self** ☐ **Spouse** ☐ **Dependent**	
Policyholder's Address (Street, City, State & Zip)		**Telephone Number**
Patient's ID Number (3 letters followed by 9 numbers)	**Group Name**	**Group Number**

OTHER INSURANCE INFORMATION

Are you or ANY family member on this policy covered by other

Medical coverage? ☐ **YES** ☐ **NO** **Vision coverage?** ☐ **YES** ☐ **NO**

Dental coverage? ☐ **YES** ☐ **NO** **With Orthodontia?** ☐ **YES** ☐ **NO**

Prescription coverage? ☐ **YES** ☐ **NO**

If YES: ☐ **Group** ☐ **Individual**

Are you or any family members covered by Medicare? ☐ **YES** ☐ **NO** **If YES:** ☐ **Part A** ☐ **Part B** ☐ **Part D**

IF THE ANSWER TO ANY OF THE ABOVE QUESTIONS IS "YES", please complete this section regarding the other insurance. If there are more than 1 additional policy, attach the requested information for each policy on a separate sheet of paper.

Name of Other Insurance	**Subscriber's Name, ID# & Birth Date**	**Subscriber's Relationship to Regence Policyholder**
Address for Submitting Claims		
This Other Insurance Covers: ☐ **Regence Policyholder's Spouse** ☐ **Regence Policyholder** ☐ **Dependants**		**If covered children are from divorced parents, indicate name of person with legal custody:**
Name of Subscriber's Employer	☐ **Active** ☐ **Retiree**	**Effective date of this plan**

Please indicate why the patient paid cash _____

I certify that the above statements are correct and hereby authorize any physician, hospital, employer, union, insurance company, or prepayment organization to supply my employer and its agents any information required in connection with this claim. A photocopy of this authorization shall be as valid as the original. I understand that it is a crime to knowingly provide false or misleading information and that doing so may result in civic or criminal prosecution.

Signed (Subscriber or Patient) _____ **Date** _____

Prescription (RX) receipts must contain:

RX number,
Date RX was filled,
Provider's name,
Drug name and NDC#,
Quantity and days supply,
Charge

Medical, Dental & Vision receipts must contain:

Provider's name and address,
Tax Identification Number,
Diagnosis and procedure codes,
Date of Service
Itemized charges

Contact the provider or pharmacy if you need additional information

TAPE RECEIPT HERE
In date order

_____
Nature of Illness or Injury

_____
Doctor's Name (if not on receipt)

_____
If Injury, Date Occurred

_____
How, When, Where

TAPE RECEIPT HERE
In date order

_____
Nature of Illness or Injury

_____
Doctor's Name (if not on receipt)

_____
If Injury, Date Occurred

_____
How, When, Where