

## **MASTER MEDICAL CLAIM FORM**

PLEASE FILL OUT ON LINE, PRINT OUT, SIGN, AND MAIL TO ADDRESS BELOW

## **INSTRUCTION FOR FILING A CLAIM**

- For each eligible family member, dependent or spouse separate all itemized bill(s), receipts(s), copies of Explanation of Benefits forms or check vouchers.
- Boxes 1 through 15 must be completed.
- If you answer "YES" to box number 14, please complete boxes 16 through 24.
- Complete a separate claim form for each eligible member. Note: Only one claim form per member is needed regardless of the number of receipts.
- Staple or paperclip each member's itemized bill(s) or receipt(s) to his/her completed claim form(s).
- All receipts submitted must include the provider signature and provider code.
- If applicable, attach copies of your Explanation of Medicare Benefits form or Medicare Benefit form or Medicare Voucher.
- Please do not peel and stick receipts to the claim form
- Save copies of all items submitted.
- Claim forms must be signed by the subscriber (contract holder, box number 15).
- Cash register receipts, cancelled checks, money order receipts, unsigned receipts or statements and personal itemizations are not acceptable and if submitted become the property of BCBSM.

NOTE: For best service, please submit your Master Medical claims to us as service occur.

SUBSCRIBER INFORMATION										
1. SUBSCRIBER'S LAST NAME 2. SUBSCRIBER'S FIRST NAME										
3. STREET ADDRESS	ress	CITY	CITY							
STATE ZIP CODE 4. CONTRAC TAKEN FR BCBSM I.	OM YOUR \	R'S CONTRACT NUMBER  5. THIS INFORMATION CATAKEN FROM YOUR BCBSM I. D. CARD	TAKEN FROM YOUR							
PATIENT INFORMATION										
6. PATIENT'S LAST NAME	IRST NAME	PATIENT'S DATE OF BIRTH								
9. PATIENTS RELATIONSHIP TO SUBSCRIBER  SELF SPOUSE DEPENDE	FOR BCBSM USE ONLY									
SELF SPOUSE DEPENDENT M F YES NO ACCIDENT   13. WORKER'S COMPENSATION? 14. OTHER HEALTH CARE COVERAGE NO IF YES, COMPLETE BOXES 16 THROUGH 24										
OTHER CARRIER INFORMATION										
16. OTHER POLICY HOLDER'S LAST NAME 17. OTHER POLICY HOLDER'S FIRST NAME 18. OTHER POLICY HOLDER'S SOCIAL SECURITY NUMBER										
19. OTHER POLICY HOLDER'S DATE OF BIRTH 20. NAME OF OTHER HEALTH CARRIER										
21. OTHER CARRIER POLICY/GROUP NUMBER 22. OTHER CARRIER STREET ADDRESS										
CITY	STATE ZIP CODE	23. OTHER EMPLOYER NAME	NAME							
24. TYPE OF OTHER HEALTH INSURANCE:  MAJOR MEDICAL DENTAL VISION PRESCRIPTION DRUGS HOSPITAL/PHYSICIAN OTHER										
CERTIFICATION STATEMENT										
I certify that the above information is true and the attached material is correct and unaltered and that the expenses were incurred by the above named patient. I understand all material submitted becomes the property of Blue Cross Blue Shield of Michigan and may not be returned. I realize false receipts or fraudulent alterations of these materials will result in civic or criminal prosecution. I authorize the release of any information necessary to process or review this claim.  ( )										
SUBSCRIBER'S SIG	NATURE (REQUIRED)	DATE	PHONE NUMBER							

## YOUR RIGHT TO CONFIDENTIALITY

We will not release any information about you except:

1) When you ask us to in writing, or 2) when release
(to another insurance company for example) is necessary
to process or review a claim. We will tell you which
information we released to whom, if you request it.

NOTE: FOR REIMBURSEMENT OF MASTER MEDICAL CLAIMS ONLY, MAIL TO:

MASTER MEDICAL DEPT., M.C. B550 BLUE CROSS BLUE SHIELD OF MICHIGAN P.O. BOX 172 DETROIT, MI 48231-0172

CLAIM NUMBER (FOR BCBSM USE ONLY)											