BlueCross BlueShield of North Carolina

SUBSCRIBER CLAIM FORM

MAIL TO: BCBSNC • PO BOX 35 • DURHAM, NC 27702-0035

FILING INSTRUCTIONS:

We encourage you to file your claims within 6 months of the service date.

Do not file a claim if the Provider or Hospital is filing for the same service.

Enclose receipts for all services and make copies for your records.

Attach an Explanation of Benefits if services are covered by another group health insurance policy.

Please do not send balance forwards, paid on account, cash register receipts or canceled checks as proof of services.

Services related to an injury, accident or medical emergency require the date of occurrence.

If services are rendered outside the USA, please submit currency used, country and a brief description of services.

Type or print legibly.

File prescription drugs on the Subscriber Prescription Drug form. You can request this form by calling the Customer Services number listed on your BCBSNC ID card.

SECTION I: PATIENT INFORMATION

ENTER SUBSCRIBER ID NUMBER HERE *(SEE ID CARD).* INCLUDE ALPHA PREFIX, IF ON ID CARD.

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(ALPHA PREFIX)

PATIENT'S LAST NAME	FIRST NAME	MI	PATIENT'S DATE OF BIRTH MONTH DAY YEAR	PATIENT'S SEX	PATIENT'S RELATIONSHIP TO MEMBER
				☐ MALE ☐ FEMALE	☐ SELF ☐ SPOUSE ☐ CHILD ☐ TWIN

IS THE PATIENT COVERED BY MEDICARE?	IS THE PATIENT COVERED BY OTHER GROUP HEALTH INSURANCE?
☐ YES **IF YES,** ☐ NO MEDICARE POLICY NUMBER:	☐ YES **IF YES,** ☐ NO EMPLOYER'S NAME:
OTHER HEALTH INSURANCE COMPANY NAME	OTHER POLICY ID NUMBER

IF INJURY, ACCIDENT OR MEDICAL EMERGENCY:	DATE OCCURRED	TYPE OF ACCIDENT OR INJURY	ON THE JOB INJURY? ☐ YES ☐ NO

Please submit the diagnosis/symptoms you sought treatment for _____

IF SERVICES WERE RENDERED OUTSIDE THE USA, PLEASE INDICATE: Country _____ Currency used _____

SECTION II: SUBSCRIBER INFORMATION

☐ **CHECK IF NEW ADDRESS**

SUBSCRIBER NAME			
STREET ADDRESS OR ROUTE AND BOX NUMBER	CITY	STATE	ZIP CODE

DAYTIME TELEPHONE	EVENING TELEPHONE

I certify that the information on this form is correct and the expenses incurred were necessary for the services filed.

Subscriber Signature _____ Date _____

SECTION III: MEDICAL SUPPLIES AND SERVICES

OFFICE VISITS, AMBULANCE, MEDICAL SUPPLIES AND FOREIGN SERVICES.
DO NOT FILE SERVICES BY A BCBS PARTICIPATING PROVIDER. THE PROVIDER SHOULD SUBMIT/FILE THE CLAIM FOR YOU.
ATTACH ORIGINAL SIGNED RECEIPTS FOR ALL MEDICAL SERVICES.
GIVE REASON, SYMPTOM OR DIAGNOSIS FOR MEDICAL SERVICES.

DATE OF SERVICE	DESCRIPTION OF SERVICE/SUPPLIES	DIAGNOSIS/SYMPTOM	CHARGE
01-10-00	Office Visit	Sore Throat	$35.00
01-11-00	Throat Culture	Sore Throat	$15.00

SECTION IV: PRIVATE DUTY NURSING

*(Note: If your coverage requires Private Duty Nursing certification, you or your doctor should call 1-800-672-7897 prior to services to request certification. Medicare Supplement coverage does **NOT** require certification.)*

DATES OF SERVICE FROM	DATES OF SERVICE TO	HOME	HOSPITAL	NAME OF NURSE	RN OR LPN	LICENSE NUMBER	HOURS	CHARGE
01-10-00	01-11-00			Ms. Jane E. Smith	RN	98765	18	$250.00

Reason for Private Nursing _____

Doctorís Signature _____ **Date** _____