BlueCross BlueShield of Minnesota

An independent licensee of the Blue Cross and Blue Shield Association

SUBSCRIBER CLAIM FORM

IDENTIFICATION NUMBER	GROUP NUMBER	**COPY THE INFORMATION FROM YOUR BLUE CROSS AND BLUE SHIELD OF MINNESOTA MEMBER ID CARD**

SUBSCRIBER'S LAST NAME	SUBSCRIBER'S FIRST NAME	SUBSCRIBER'S BIRTHDATE MO / DAY / YR
PATIENT'S LAST NAME	PATIENT'S FIRST NAME	PATIENT'S BIRTHDATE MO / DAY / YR

PATIENT'S SEX: ☐ MALE ☐ FEMALE

PATIENT'S RELATIONSHIP TO SUBSCRIBER: ☐ SELF ☐ SPOUSE ☐ UNMARRIED DEPENDENT

IS CONDITION JOB RELATED? ☐ YES ☐ NO

SUBSCRIBER'S STREET ADDRESS	CITY	STATE	ZIP CODE	FOREIGN CLAIM? YES ☐ NO ☐

IS THIS SERVICE RELATED TO: ☐ ILLNESS ☐ INJURY ☐ MATERNITY ☐ AUTO ACCIDENT

MO. DAY YR.

IF ILLNESS, DATE OF FIRST SYMPTOM
IF INJURY or ACCIDENT, DATE OF INJURY or ACCIDENT
IF MATERNITY, DATE OF LAST MENSTRUAL PERIOD

IF HOSPITALIZED:	ADMISSION DATE MO	DAY	YR.	DISCHARGE DATE MO.	DAY	YR.	NAME OF ADMITTING PHYSICIAN	NAME OF HOSPITAL

SYMPTOMS AND/OR DIAGNOSIS

NAME OF PROVIDER	PROVIDERS ADDRESS

OTHER COVERAGE INFORMATION

For claims related to an injury or auto accident, please provide the name and address of the other carrier, if applicable.

IDENTIFICATION NUMBER _____GROUP NUMBER_____

NAME OF INSURANCE COMPANY _____

ADDRESS _____

YOU MUST INCLUDE A COPY OF YOUR EXPLANATION OF BENEFITS, if you have other health care insurance as primary coverage, have an auto or worked related injury, or have Medicare benefits

Does the patient have other insurance coverage? Yes ☐ No ☐

IDENTIFICATION NUMBER _____GROUP NUMBER _____

NAME OF INSURANCE COMPANY _____

ADDRESS _____

Does the patient have Medicare Coverage: Yes ☐ No ☐

MEDICARE NUMBER _____

Is the patient eligible for Medicare Part A? Yes ☐ No ☐

Is the patient eligible for Medicare Part B? Yes ☐ No ☐

I hereby certify that the statements provided by me are correct and acknowledge that I will refund to Blue Cross and Blue Shield of Minnesota duplicate payments to myself from other sources because of coordination of benefits. I authorize the provider of services, named above, to release the information requested on this form to Blue Cross and Blue Shield of Minnesota. **A person who files a claim with the intent to defraud or helps commit a fraud against an insurer is guilty of a crime.**

Signature _____ Date Signed _____

IMPORTANT, PLEASE READ THE FOLLOWING: Claims must be submitted within the timeframe specified by your contract. The claim form must be completed using **BLACK** ink.

HOW TO SUBMIT YOUR CLAIM:

1. Complete a separate Subscriber Claim Form for each patient and for each provider.
2. Answer all questions.
3. Attach a copy of the **itemized bill**. The bill should show:
   - the provider's name and address
   - the diagnosis or symptoms of illness
   - the date, place and type of service
   - the charge for each service
4. Attach a copy of your Explanation of Health Care Benefits, if you have other coverage as primary.
   Note: We cannot return the claim or documentation that you send. Please make copies for your personal files.

Mail this form to:
Blue Cross and Blue Shield of Minnesota
PO Box 64338
St. Paul, MN 55164-0038