MASSACHUSETTS

Medex® Subscriber Claim Form

Medex Identification Number								

Important: Take this number from your Medex ID Card.

Please read the instructions on the reverse side of this form and print clearly in the required boxes. **NOTE:** This should not be used to submit a drug claim if you are a direct-pay member. Instead, please fill out a separate MEDEX DRUG CLAIM FORM.

Part I

Last Name	First	M.I.	Medicare Health Insurance Claim Number
Street Address			Date of Birth (MM/DD/YYYY)
City	State	Zip Code	☐ Male ☐ Female

Part II Please Give the Dates of Your Most Recent Hospitalization

Hospital's Name				Admission Date: (MM/DD/YY)
Street Address	City	State	Zip Code	Discharge Date: (MM/DD/YY)

Part III Claim Information (Attach Itemized Bills)

Type of Service	Provider Name and Address	Diagnosis or Illness	Date of Service MO DAY YR	Amount Charged	Office Use Only

Part IV

Total Number of Bills Attached: _____ Total Charges $ _____

☐ Pay Subscriber ☐ Pay Provider

See Reverse: Please Date and Sign Your Name in the Space Provided

INSTRUCTIONS:

Attach the Medicare Explanation of Benefits for all hospital and physician claims.

Submit claims to:
Blue Cross Blue Shield of Massachusetts
P.O. Box 986030
Boston, MA 02298

Note: All out-of-country bill must be translated into English and US currency.

Claim Checklist

Please review this checklist before sending your claim to us.
Incomplete forms may be returned to you.

- ☐ Have you listed your Medex Identification Number in the space provided?
- ☐ Have you listed a diagnosis or illness on each line of the claim information section?
- ☐ Have you listed the total charges for this claim?
- ☐ Have you attached original itemized bills for your pharmacy and out-of-country claims?
- ☐ Have you attached all related Explanation of Benefits or Explanation of Medicare Benefits forms you may have received previously for these services?
- ☐ Have you signed and dated the completed claims form?
- ☐ Have you kept a copy of all receipts and EOB'S?

Certification and Authorization:

I authorize the release of any information to Blue Cross and Blue Shield about my examination and treatment. I certify that the information provided in the support of this claim is complete and correct and that I have not been previously reimbursed for these services.

X _____ _____

Subscriber's Signature Date