P.O. Box 91059
Seattle, WA 98111-9159
Toll free 800-722-1471

PREMERA | BLUE CROSS

MEMBER CLAIM FORM

Please use a separate claim form for each patient and each provider of service (such as doctor or laboratory).

All information that is applicable to the claim being submitted must be completed. Leaving any applicable questions unanswered may cause your claim to be returned and processing to be delayed until the information is completed.

When you've answered all the questions below, turn the form over and complete the section of page 2 that applies to your claim.

Do not use this form for prescription reimbursement. Please use the *Prescription Drug Reimbursement Form* for primary prescription claim submission and the *Secondary Insurance Prescription Drug Claim Form* for secondary prescription claim submission. (Call the Customer Service number listed on the back of your ID card for the proper form.)

1. WHO IS THE PATIENT?

Name (First—Middle—Last)

Gender ☐ Male ☐ Female

Birthdate (Month/Day/Year) / /

If the patient is a dependent child of divorced parents, who has legal custody? ☐ Mother ☐ Father ☐ _____

Who has financial responsibility under the divorce decree? _____

What is the patient's relationship to the subscriber?
☐ Self ☐ Spouse ☐ Child ☐ Other _____

Is the patient:
A full-time student? ☐ No ☐ Yes
Physically or developmentally disabled? ☐ No ☐ Yes

If the patient received the care outside the United States of America, what is the name of the country?

2. WHO IS THE SUBSCRIBER? (PERSON IN WHOSE NAME COVERAGE WITH PREMERA BLUE CROSS IS ESTABLISHED)

Name (First—Middle—Last)

Prefix and Identification # (Please copy from your ID card)
☐☐☐ ☐☐☐☐☐☐☐☐☐☐

Employer

Group Number (please copy from your ID card)

Subscriber is
☐ Actively employed
☐ Retired ☐ Laid off

Mailing Address

☐ Check here if this is a new address

Telephone Numbers
Daytime ( )
Evening ( )

3. PLEASE ANSWER THE FOLLOWING QUESTIONS.

A. Payment information: Have these charges been paid in full? ☐No ☐Yes, please attach proof of payment in full with claim submission.

B. Does the patient have other medical (other than Medicare), dental or vision coverage? ☐No ☐Yes If "Yes," what is the:

Subscriber's Name Identification Number Birthdate / / (Month/Day/Year)

Employer's Name Address Phone No. Group No.

Other Insurance Co. Name Address Phone No.

Other insurance covers: ☐Medical ☐Dental ☐Vision

C. If covered by Medicare, check the type of Medicare coverage the patient has and enter the date this coverage went into effect.
☐ Part A (Hospital) _____/_____/_____ ☐ Part B (Medical) _____/_____/_____ ☐ Part D (Rx) _____/_____/_____

Reason (check all that apply): ☐ Age ☐ Disability ☐ End Stage Renal Disease Name of Part D Carrier: _____

What is the Medicare identification number **(must complete)**? ☐☐☐☐☐☐☐☐☐☐

What is the patient's Social Security number **(must complete)**? ☐☐☐-☐☐-☐☐☐☐

D. Did the condition result from an accident? ☐No ☐Yes If "Yes," complete ACCIDENT INFORMATION on PAGE 2.

E. Have you been treated for this condition before? ☐No ☐Yes If "Yes," list dates treated ____/__/____/__/____

F. What was the exact date the condition started? (Month/Day/Year) ____/__/____

G. Is this expense pregnancy-related? ☐No ☐Yes If "Yes," what was the date of conception? ____/__/____

H. In what setting were these services performed?
☐Inpatient Hospital ☐Outpatient Hospital ☐Office/Clinic ☐Surgery Center ☐Skilled Nursing Facility ☐Home
☐Other _____

An **itemized bill** is a form the provider uses that details the services received by the member and the cost of each service. It is not a statement which shows only the balance due. Please do not highlight or modify receipts as this may cause delayed processing of your claim.

Complete a separate claim form for each provider of service, such as doctor or laboratory.
Please do not use for more than one provider or patient.

4. FOR DENTAL CLAIM (ITEMIZED BILL MUST BE ATTACHED)

A. Was the treatment for orthodontic care? ☐No ☐Yes

B. Did treatment include an artificial device(s) such as dentures, bridge(s), crown(s), etc.? ☐No ☐Yes

If "Yes," was the treatment to replace an existing artificial device?_____

If "Yes," please explain why the replacement was necessary and give the date (if known) of the last replacement. _____

_____

5. FOR VISION CLAIM (ITEMIZED BILL MUST BE ATTACHED)

If lenses were prescribed, what type? ☐Single ☐Bifocal ☐Trifocal ☐Contact ☐Other (please specify) _____

6. FOR ALL OTHER CLAIMS — DOCTOR, CLINIC, LAB, ETC. (ITEMIZED BILL MUST BE ATTACHED)

What was the condition requiring treatment? (Diagnosis)

_____

_____

_____

_____

_____

_____

☐Check here if routine physical examination

Is the condition work related? ☐No ☐Yes

Has the patient or will the patient file a workers' compensation claim? ☐No ☐Yes

Is this a second surgical opinion? ☐No ☐Yes

Is this a third surgical opinion? ☐No ☐Yes

Surgical procedure _____

_____

_____

_____

_____

_____

ACCIDENT INFORMATION

Was the reason for treatment due to an accident? ☐No ☐Yes

Where did the accident occur?
☐At work ☐At home ☐Auto ☐Other _____

What was the exact date of the accident/injury? _____ / _____ / _____
(Month / Day / Year)

If auto accident, do you have:

Personal injury protection? ☐No ☐Yes

Uninsured or underinsured coverage? ☐No ☐Yes

Medical payment coverage? ☐No ☐Yes

Name and address of auto insurance company:

_____

_____

_____

_____

_____

Do you intend to make a claim against a third party? ☐No ☐Yes

Please note: *It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.*

X _____ / _____ / _____

Patient's signature (or legal guardian if patient cannot legally consent to services) Date (Month/Day/Year)

To be accepted, this form must be fully completed (as applicable to the claim being submitted), signed, and have proper bills attached.

Mail to: Premera Blue Cross
P.O. Box 91059
Seattle, WA 98111-9159