



A nonprofit independent licensee of the BlueCross BlueShield Association

PLEASE REVIEW AND LEGIBLY COMPLETE ALL SECTIONS (1-5) OF THIS FORM

*Please Note-If you do not have all of the required information, please contact the provider of service for assistance prior to submitting your claim. Failure to supply all of the required information may result in delayed processing and/or subsequent return or denial of your claim submission.
If your address has changed or is incorrect, please call our Customer Service Department at the telephone numbers listed on your identification card.*

**MEDICAL BENEFITS
SUBSCRIBER CLAIM FORM**

Mail completed form and all required information to:

**Excellus BlueCross BlueShield
P.O. Box 22999
Rochester, NY 14692**

**SECTION 1
INFORMATION REQUIRED FROM SUBSCRIBER**

1a-HAVE SUBMITTED EXPENSES BEEN PAID IN FULL BY YOU? YES NO
Please Note-If a participating provider rendered the service(s) being submitted, payment will be made directly to the provider.

1b-ITEMIZED BILL(S) FOR SERVICES OR SUPPLIES **MUST BE SUBMITTED WITH THIS FORM IN ORDER FOR REIMBURSEMENT TO BE CONSIDERED. THE ITEMIZED BILL MUST CLEARLY INDICATE ALL OF THE FOLLOWING:**

1-PATIENT'S FULL NAME AND DATE OF BIRTH	4-DESCRIPTION AND/OR VALID PROCEDURE CODE FOR EACH SERVICE RENDERED	7-COUNTRY MUST BE INDICATED AND ALL INFORMATION TRANSLATED TO ENGLISH FOR ANY SERVICE(S) NOT RENDERED IN THE USA
2-NAME AND ADDRESS OF THE PROVIDER OF SERVICE ON THEIR OFFICE LETTERHEAD, INCLUDING PROVIDER ID NUMBER AND CREDENTIALS	5-CHARGE FOR EACH SERVICE RENDERED	8-PRESCRIPTION NUMBER AND NAME OF PRESCRIBING PHYSICIAN MUST BE INDICATED ON RX/MEDICINE BILLS
3-DATE FOR EACH SERVICE RENDERED	6-DESCRIPTION OF ILLNESS/INJURY AND/OR VALID DIAGNOSIS CODE FOR EACH SERVICE RENDERED	

**SECTION 2
SUBSCRIBER/PATIENT INFORMATION** *Please enter all information exactly as shown on your ID card*

2a-SUBSCRIBER'S LAST NAME	2b-FIRST NAME	2c-INITIAL	2d-SUBSCRIBER IDENTIFICATION NUMBER (Including Prefix)	
2e-ADDRESS-NUMBER AND STREET		2f-CITY	2g-STATE	2h-ZIP CODE
2i-PATIENT'S LAST NAME	2j-FIRST NAME	2k-INITIAL	2l-DATE OF BIRTH mm / dd / yyyy	2m-GENDER <input type="checkbox"/> M <input type="checkbox"/> F
			2n-PATIENT'S RELATIONSHIP TO SUBSCRIBER <input type="checkbox"/> SELF <input type="checkbox"/> CHILD <input type="checkbox"/> SPOUSE	

**SECTION 3
OTHER HEALTH INSURANCE INFORMATION**

3a-IS THE PATIENT COVERED BY ANOTHER HEALTH INSURANCE PLAN (INCLUDING MEDICARE)? YES NO
If YES, please complete 3b-3g below

3b-NAME OF OTHER POLICYHOLDER

3c-POLICY OR IDENTIFICATION NUMBER

3d-POLICY EFFECTIVE DATE: mm / dd / yyyy

3e-TYPE OF POLICY/COVERAGE: INDIVIDUAL TWO-PERSON FAMILY

3f-POLICYHOLDER'S DATE OF BIRTH: mm / dd / yyyy

3g-NAME AND ADDRESS OF OTHER INSURANCE CARRIER

Please Note-If the patient has other primary insurance, the Explanation of Benefits form(s) from the other health insurance plan must accompany this claim form, along with the matching itemized bill.

**SECTION 4
MOTOR VEHICLE/WORK-RELATED INFORMATION**

4a-ARE THE SUBMITTED EXPENSES RELATED, IN ANY WAY, TO A MOTOR VEHICLE OR WORK-RELATED ACCIDENT OR INJURY?
 YES NO
If YES, please complete 4b & 4c below

4b-TYPE OF ACCIDENT: WORK MOTOR VEHICLE OTHER

4c-DATE OF ACCIDENT OR INJURY: mm / dd / yyyy

**SECTION 5
SIGNATURE AND DATE**

I CERTIFY THAT THE INFORMATION SUBMITTED IS ACCURATE TO THE BEST OF MY KNOWLEDGE. I AUTHORIZE THE RELEASE OF ANY RELEVANT INFORMATION TO MY INSURANCE CARRIER.

SUBSCRIBER SIGNATURE: _____ DATE: _____

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information, or conceals information concerning any fact material thereto, for the purpose of misleading, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed \$5,000 and the stated value of each violation.