

# Subscriber Claim Form

## Instructions for Submitting Claims

1. Submit a claim only when you are billed for services from a provider that does not directly submit a claim to the local Blue Cross Blue Shield plan.
2. Submit a separate form for each patient.
3. Attach an **original** itemized bill from your provider (**required information and example on the back**)
4. Keep a copy of all bills and claim forms submitted (originals will not be returned)
5. Be sure to sign and date the completed form.
6. Mail claim form and all attachments to **BCBSMA, P.O. Box 986030, Boston, MA 02298**

## Subscriber Information

|  |                 |            |                |
|--|-----------------|------------|----------------|
| Identification Number (including alpha prefix) | Last Name       | First Name | Middle Initial |
| Address-Number & Street                        | City            | State      | Zip Code       |
| Date of Birth (MM/DD/YY)                       | Employer's Name |            |                |

## Patient Information

|   |   |                |                          |
|---|---|----------------|--------------------------|
| Patient Last Name   | First Name  | Middle Initial | Date of Birth (MM/DD/YY) |
| Gender:<br><input type="checkbox"/> Male<br><input type="checkbox"/> Female | Patient is:<br><input type="checkbox"/> Subscriber (contract holder) <input type="checkbox"/> Spouse (to contract holder) <input type="checkbox"/> Child (age 18 or younger)<br><input type="checkbox"/> Student (age 19 or older) <input type="checkbox"/> Handicapped Dependent (age 19 or older)<br><input type="checkbox"/> Other (specify) _____ |                |                          |

|   |  |
|---|--|
| Does the patient have other insurance: <input type="checkbox"/> Yes <input type="checkbox"/> No<br>Effective Date: _____<br>Medicare Part A (Hospital) <input type="checkbox"/> Yes <input type="checkbox"/> No ____/____/____<br>Medicare Part B (Medical) <input type="checkbox"/> Yes <input type="checkbox"/> No ____/____/____<br>Medicare Part A (Pharmacy) <input type="checkbox"/> Yes <input type="checkbox"/> No ____/____/____<br>Other Blue Cross Blue Shield Membership? <input type="checkbox"/> Yes <input type="checkbox"/> No ____/____/____<br>Other Insurance Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No ____/____/____<br>Identification Number: _____<br>Name and address of other insurance:<br>_____ | Was treatment for:<br>Accident at work? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>Date of accident ____/____/____<br>Auto accident? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>Date of accident ____/____/____<br>If yes, name of auto insurance:<br>_____<br>Policy Number: _____<br>Other accident? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>Date of accident ____/____/____ |
|---|--|

|                             |             |
|-----------------------------|-------------|
| Subscriber Signature: _____ | Date: _____ |
|-----------------------------|-------------|

Please allow up to 30 days for your claim to process.

### Example of a Complete Itemized Bill

|  |  |
|--|--|
| Smith Speech Center<br>123 Main St.<br>Boston, MA 12345                    |  |
| To: Joe Smith<br>15 Elm St.<br>Anytown, MA 12345                           | Patient Name: Joan Smith<br>Referring Doctor: Dr. John Jones |
| Jane Johnson, SLP, CCC<br>Speech-Language Pathologist<br>License # Y777777 | NPI: 99-9999999  |

| Procedure Code(s)               | Units | Procedure Description   | Date of Service | Amount                     |
|---------------------------------|-------|-------------------------|-----------------|----------------------------|
| 92507                           | 1     | Speech-Language Therapy | 10/5/2008       | \$72.50                    |
| 92507                           | 2     | Speech-Language Therapy | 11/3/2008       | \$145.00                   |
| Diagnosis Codes: 784.50, 315.31 |       |                         |                 | <b>Total:</b> \$290.00     |
|                                 |       |                         |                 | <b>Payments:</b> \$290.00  |
|                                 |       |                         |                 | <b>Balance Due:</b> \$0.00 |

Please note that your bill does not need to look exactly like the example above, but **MUST** contain the following required information:

- A letterhead from the provider that **MUST** include all of the following:
  - Provider name
  - Provider address
  - Provider NPI or License Number
  - Provider credentials, i.e., the initials associated with the educational degrees the provider has earned. Examples include: MD, LICSW, DC, PT, OT, ST
- Patient's name
- Date(s) of service
- Itemized charges for each date of service and type of service received
- Procedure codes (HCPCS/Revenue codes) for all services received
- Diagnosis code(s) for services received
- Number of Units-this is the number of times a service was performed on a particular date of service. This is required for occupational, physical & speech therapies, anesthesia and chiropractic services.
- Attach any related claim summaries or Explanation of Medicare Benefit Forms you may have received for these services, including those received from other insurance companies.
- When submitting a claim for **PRESCRIPTION DRUGS**, you must submit an itemized receipt from your pharmacy that includes:
  - National Drug Code (NDC)
  - Name of drug
  - Date dispensed
  - Quantity dispensed
  - Name of prescribing physician

To view processed claims, visit our website <http://www.bluecrossma.com/wps/portal/members/>. If you have not already registered for **Member Central**, click **Create an Account** and follow the directions.

