



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		PATIENT'S RELATIONSHIP TO SUBSCRIBER			IS CONDITION JOB RELATED?			
<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		<input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> UNMARRIED DEPENDENT			<input type="checkbox"/> YES <input type="checkbox"/> NO			
SUBSCRIBER'S STREET ADDRESS			CITY		STATE	ZIP CODE	FOREIGN CLAIM?	
							YES <input type="checkbox"/> NO <input type="checkbox"/>	
IS THIS SERVICE RELATED TO:				MO.	DAY	YR.		
<input type="checkbox"/> ILLNESS <input type="checkbox"/> INJURY <input type="checkbox"/> MATERNITY <input type="checkbox"/> AUTO ACCIDENT						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		DISCHARGE DATE			NAME OF ADMITTING PHYSICIAN	NAME OF HOSPITAL
		MO	DAY	YR.	MO.	DAY	YR.	
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.						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		
IDENTIFICATION NUMBER _____ GROUP NUMBER _____								
NAME OF INSURANCE COMPANY _____								
ADDRESS _____								
Does the patient have other insurance coverage? Yes <input type="checkbox"/> No <input type="checkbox"/>						Does the patient have Medicare Coverage: Yes <input type="checkbox"/> No <input type="checkbox"/>		
IDENTIFICATION NUMBER _____ GROUP NUMBER _____						MEDICARE NUMBER _____		
NAME OF INSURANCE COMPANY _____						Is the patient eligible for Medicare Part A? Yes <input type="checkbox"/> No <input type="checkbox"/>		
ADDRESS _____						Is the patient eligible for Medicare Part B? Yes <input type="checkbox"/> No <input type="checkbox"/>		
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