



**BlueCross
BlueShield**
Minnesota

SUBSCRIBER CLAIM FORM

This claim form must be completed using **Black** ink.

Blue Cross® and Blue Shield® of Minnesota and Blue Plus® are nonprofit independent licensees of the Blue Cross and Blue Shield Association

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 with the timeframe specified by your contract.

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 and Federal tax ID or National Provider Identifier (NPI)
 - the diagnosis or the 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 55164-0338

Fax this form to:

651-662-7933

Email this form to:

ISC.Subscriber.Claims@bluecrossmn.com

This information is also available in other ways to people with disabilities by calling customer service at **(651) 662-8000** (voice), or **1-800-382-2000** (toll free).

For TTY:

Call **(651) 662-8700**, or **1-888-878-0137** (TTY), or 711, or through the Minnesota Relay direct access numbers at **1-800-627-3529** (TTY, Voice, ASCII, Hearing Carry Over), or **1-877-627-3848** (Speech-to-Speech).

Hours: 7 a.m. to 8 p.m. Central Time, Monday through Friday

Attention: If you want free help translating this information, call the above number.

Atención: Si desea ayuda gratis para traducir esta información, llame al número que aparece arriba.