**BlueCross BlueShield**
Minnesota

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

# SUBSCRIBER CLAIM FORM

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

| 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 ☐ MALE ☐ FEMALE | PATIENT'S RELATIONSHIP TO SUBSCRIBER ☐ SELF ☐ SPOUSE ☐ UNMARRIED DEPENDENT | IS CONDITION JOB RELATED? ☐ YES ☐ NO |

| SUBSCRIBER'S STREET ADDRESS | CITY | STATE | ZIP CODE | FOREIGN CLAIM? YES ☐ NO ☐ |
|---|---|---|---|---|
| | | | | |

| IS THIS SERVICE RELATED TO: | MO. | DAY | YR. | |
|---|---|---|---|---|
| ☐ ILLNESS ☐ INJURY ☐ MATERNITY ☐ AUTO ACCIDENT | | | | IF ILLNESS, DATE OF FIRST SYMPTOM<br>IF INJURY or ACCIDENT, DATE OF INJURY or ACCIDENT<br>IF MATERNITY, DATE OF LAST MENSTRUAL PERIOD |

| | ADMISSION DATE | | | DISCHARGE DATE | | | NAME OF ADMITTING PHYSICIAN | NAME OF HOSPITAL |
|---|---|---|---|---|---|---|---|---|
| IF HOSPITALIZED: | 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.

IDENTIFICATION NUMBER ____________________________GROUP NUMBER__________________

NAME OF INSURANCE COMPANY ______________________________________________________

ADDRESS ________________________________________________________________________

**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

Does the patient have other insurance coverage? Yes ☐ No ☐

IDENTIFICATION NUMBER ____________________________GROUP NUMBER ________________

NAME OF INSURANCE COMPANY ______________________________________________________

ADDRESS ________________________________________________________________________

Does the patient have Medicare Coverage: Yes ☐ No ☐

MEDICARE NUMBER ____________________________

Is the patient eligible for Medicare Part A? Yes ☐ No ☐

Is the patient eligible for Medicare Part B? Yes ☐ No ☐

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.