



**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

COPY THE INFORMATION FROM YOUR BLUE CROSS AND BLUE SHIELD OF MINNESOTA MEMBER ID CARD	
IDENTIFICATION NUMBER	GROUP NUMBER
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
<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	<input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> UNMARRIED DEPENDENT
IS CONDITION JOB RELATED?	
<input type="checkbox"/> YES <input type="checkbox"/> NO	
SUBSCRIBER'S STREET ADDRESS	CITY
STATE	ZIP CODE
FOREIGN CLAIM?	
<input type="checkbox"/> YES <input type="checkbox"/> NO	
IS THIS SERVICE RELATED TO:	
<input type="checkbox"/> ILLNESS <input type="checkbox"/> INJURY <input type="checkbox"/> MATERNITY <input type="checkbox"/> AUTO ACCIDENT	MO. DAY YR.
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
MO	DAY
YR.	
MO.	DAY
YR.	
DISCHARGE DATE	
NAME OF ADMITTING PHYSICIAN	
NAME OF HOSPITAL	
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 <input type="checkbox"/> No <input type="checkbox"/> IDENTIFICATION NUMBER _____ GROUP NUMBER _____ NAME OF INSURANCE COMPANY _____ ADDRESS _____	Does the patient have Medicare Coverage: Yes <input type="checkbox"/> No <input type="checkbox"/> MEDICARE NUMBER _____ Is the patient eligible for Medicare Part A? Yes <input type="checkbox"/> No <input type="checkbox"/> 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 982805
El Paso, TX 79998-2805

Email this form to:

ISC.Subscriber.Claims@bluecrossmn.com

NOTICE OF NONDISCRIMINATION PRACTICES

Effective July 18, 2016

Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or gender. Blue Cross does not exclude people or treat them differently because of race, color, national origin, age, disability, or gender.

Blue Cross provides resources to access information in alternative formats and languages:

- Auxiliary aids and services, such as qualified interpreters and written information available in other formats, are available free of charge to people with disabilities to assist in communicating with us.
- Language services, such as qualified interpreters and information written in other languages, are available free of charge to people whose primary language is not English.

If you need these services, contact us at 1-800-382-2000 or by using the telephone number on the back of your member identification card. TTY users call 711.

If you believe that Blue Cross has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or gender, you can file a grievance with the Nondiscrimination Civil Rights Coordinator

- by email at: Civil.Rights.Coord@bluecrossmn.com
- by mail at: Nondiscrimination Civil Rights Coordinator
Blue Cross and Blue Shield of Minnesota and Blue Plus
M495
PO Box 64560
Eagan, MN 55164-0560
- or by phone at: 1-800-509-5312

Grievance forms are available by contacting us at the contacts listed above, by calling 1-800-382-2000 or by using the telephone number on the back of your member identification card. TTY users call 711. If you need help filing a grievance, assistance is available by contacting us at the numbers listed above.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights

- electronically through the Office for Civil Rights Complaint Portal, available at: <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>
- by phone at:
1-800-368-1019 or 1-800-537-7697 (TDD)
- or by mail at:
U.S. Department of Health and Human Services
200 Independence Avenue SW
Room 509F
HHH Building
Washington, DC 20201

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

This information is available in other languages. Free language assistance services are available by calling the toll free number below. For TTY, call 711.

Si habla español, tiene a su disposición servicios gratuitos de asistencia con el idioma. Llame al 1-855-903-2583. Para TTY, llame al 711.

Yog tias koj hais lus Hmoob, muaj kev pab txhais lus pub dawb rau koj. Hu rau 1-800-793-6931. Rau TTY, hu rau 711.

Haddii aad ku hadasho Soomaali, adigu waxaad heli kartaa caawimo luqad lacag la'aan ah. Wac 1-866-251-6736. Markay tahay dad maqalku ku adag yahay (TTY), wac 711.

နမ့်ကတိကပီကိုးခိး, တၢ်ကဟ့ၣ်နၢ်ကိုးတၢ်မၤစၢၤကလိတဟ့ၣ်န့ၣ်လိၤ. ကိး 1-866-251-6744 လၢ TTY အကို, ကိး 711 တကို.

إذا كنت تتحدث العربية، تتوفر لك خدمات المساعدة اللغوية المجانية. اتصل بالرقم 1-866-569-9123. للهاتف النصي اتصل بالرقم 711.

Nếu quý vị nói Tiếng Việt, có sẵn các dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Gọi số 1-855-315-4015. Người dùng TTY xin gọi 711.

Afaan Oromoo dubbattu yoo ta'e, tajaajila gargaarsa afaan hiikuu kaffaltii malee. Argachuuf 1-855-315-4016 bilbilaa. TTY dhaaf, 711 bilbilaa.

如果您說中文，我們可以為您提供免費的語言協助服務。請撥打 1-855-315-4017。聽語障專 (TTY)，請撥打 711。

Если Вы говорите по-русски, Вы можете воспользоваться бесплатными услугами переводчика. Звоните 1-855-315-4028. Для использования телефонного аппарата с текстовым выходом звоните 711.

Si vous parlez français, des services d'assistance linguistique sont disponibles gratuitement. Appelez le +1-855-315-4029. Pour les personnes malentendantes, appelez le 711.

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한국어를 사용하시는 경우, 무료 언어 지원 서비스가 제공됩니다. 1-855-904-2583 으로 전화하십시오. TTY 사용자는 711 로 전화하십시오.

ຖ້າເຈົ້າເວົ້າພາສາລາວໄດ້, ມີການບໍລິການຊ່ວຍເຫຼືອພາສາໃຫ້ເຈົ້າຟຣີ. ໃຫ້ໂທຫາ 1-866-356-2423 ສໍາລັບ TTY, ໃຫ້ໂທຫາ 711.

Kung nagsasalita kayo ng Tagalog, mayroon kayong magagamit na libreng tulong na mga serbisyo sa wika. Tumawag sa 1-866-537-7720. Para sa TTY, tumawag sa 711.

Wenn Sie Deutsch sprechen, steht Ihnen fremdsprachliche Unterstützung zur Verfügung. Wählen Sie 1-866-289-7402. Für TTY wählen Sie 711.

ប្រសិនបើអ្នកនិយាយភាសាខ្មែរមិន អ្នកអាចរកបានសេវាជំនួយភាសាឥតគិតថ្លៃ។ ទូរស័ព្ទមកលេខ 1-855-906-2583។ សម្រាប់ TTY សូមទូរស័ព្ទមកលេខ 711។

Diné k'ehjí yánílt'i'go saad bee yát'i' éí t'áájíík'e bee níká'a'doowołgo éí ná'ahoot'i'. Kojí éí béesh bee hodíílnih 1-855-902-2583. TTY biniiyégo éí 711 jì' béesh bee hodíílnih.

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