SUBSCRIBER CLAIM FORM

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

BlueCross BlueShield Minnesota

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 ☐ 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: ☐ ILLNESS ☐ INJURY ☐ MATERNITY ☐ 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

	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 _____

Note: Claims must be submitted within 12 months of date of service.

How to submit your claim:

1. Complete a *separate* Subscriber Claim Form for each patient and for each provider.
2. Complete all applicable fields.
3. Attach a copy of the **itemized bill** from the provider. The bill **must** include:
   - Provider name, address, and Federal Tax ID or National Provider Identifier (NPI)
   - Date(s) of service
   - Diagnosis code(s) (a combination of 3 to 7 letters and/or numbers assigned to a particular diagnosis; there will usually be a decimal point after the first 3 numbers)
   - Procedure code(s) (5 numbers or 1 letter followed by 4 numbers)
   - Place of Service code (2-digit number; only applies to non-hospital charges) OR
   - Type of Bill code (3-digit number; only applies to hospital charges)
   - Individual Charge for each service performed
4. If you have other insurance primary to your BCBSMN insurance, please submit a claim with them first. Then, when you submit this claim, please include a copy of the Explanation of Health Care Benefits you will receive from your primary insurance.
5. You may include any other additional documents related to the service, as necessary.

Note: We cannot process your claim without all of the information listed above. If any of the above items are missing, please contact the provider of the service(s) to obtain the information. Also, please make copies for your personal files, as we cannot return the claim or documentation that you send.

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

BlueCross BlueShield Minnesota

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.

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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.

နမ့်ကတိၤကညီကျိာ်ဒီး, တ၊်ကဟ့ဉ်နၤကျိာ်တ၊်မၤစ၊ၤကလိတဖဉ်နှဉ်လိၤ. ကိး 1-866-251-6744 လ၊ TTY အဂိ၊်, ကိး 711 တက့၊်.

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.

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

Diné k'ehjí yáníłt'i'go saad bee yát'i' éí t'áájíík'e bee níká'a'doowołgo éí ná'ahoot'i'. Kojį éí béésh bee hodíílnih 1-855-902-2583. TTY biniiyégo éí 711 jį’ béésh bee hodíílnih.

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