Digital Application for Contraception Management
Member Reimbursement Form

Please use this form to request reimbursement for your annual or monthly subscription. To process your claim, we need you to include all the information requested on this form.

- A separate claim form must be submitted for each member covered under your plan
- Incomplete forms may result in a payment delay
- Please make a copy for your personal files because we cannot return the documents that you send
- Final eligibility and payment will be based on plan benefits
- Eligible reimbursement will be mailed to the contract holder/ subscriber

How to submit your claim:

- Complete all fields
- Attach a copy of the itemized receipt(s) or proof of purchase
- Receipt must include the name of the application and date of purchase
- Note: The basal thermometer and tax on purchase are not reimbursable costs

Send completed forms and receipts by mail: Blue Cross and Blue Shield of Minnesota
PO Box 64179
St. Paul MN 55164

To be eligible, the following criteria applies:

- Must be Food and Drug Administration (FDA) approved, cleared, or granted for contraception management
- Application must be purchased on or after January 1, 2022
- Must be used for contraceptive purposes
- Members are eligible for reimbursement only when this plan is the primary coverage at the time of purchase
- Claims must be submitted within the timeframe defined in plan benefits

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BlueCross BlueShield Minnesota

Provide the following:

- Name of the digital application _____
- Type of subscription purchased: Choose one selection
  - ☐ Annual: Cost per year_____
  - ☐ Monthly: Cost per month _____
- Date(s) submitted for reimbursement MM/DD/YYYY _____

Copy the information from your Blue Cross and Blue Shield of Minnesota Member ID Card		
Identification Number	Group Number	Patient's Relationship to Subscriber ☐ Self ☐ Spouse ☐ Dependent
Subscriber's Last Name	Subscriber's First Name	Subscriber's Birthdate
Subscriber's Street Address	City	State Zip Code
Patient's Last Name	Patient's First Name	Patient's Birthdate
Patient's Street Address	City	State Zip Code

Other Coverage Information

Does the patient have other insurance coverage Yes ☐ No ☐
Identification Number _____
Group Number _____
Name of Insurance Company _____
Address _____
City _____ State_____ Zip_____

I certify that the charges I am submitting for reimbursement are eligible and were incurred for contraception management. I also understand that reimbursed expenses are not tax-deductible. I hereby certify that the statements provided by me are correct and acknowledge that I will refund Blue Cross and Blue Shield of Minnesota duplicate payments to myself from other sources because of coordination of benefits.

Note: A person who files a claim with the intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

☐ I understand that by typing my name in the line below constitutes a legal signature.

_____ _____

Signature **Date**