P.O. Box 91059, Seattle, WA 98111-9159
Toll Free 800-722-1471

PREMERA BLUE CROSS

SUBSCRIBER CLAIM FORM

☐ Check this box if you need more Subscriber Claim Forms.

Please use a separate claim form for each patient and each provider of service (such as doctor or laboratory).

Leaving any questions unanswered on this form may cause your claim to be returned and processing to be delayed until the information is completed.

When you've answered all the questions below, turn the form over and complete the section of page 2 that applies to your claim.

This form must be filled out completely.

Do not use this form for prescription reimbursement. Please use the *PAID Prescriptions* Claim Form. (Call the Customer Service number listed on the back of your ID card for the proper form.)

1. WHO IS THE PATIENT?

Name (First—Middle—Last)

Gender ☐ Male ☐ Female

Birthdate (Month/Day/Year) / /

If the patient is a dependent child of divorced parents, who has legal custody? ☐ Mother ☐ Father ☐ _____

Who has financial responsibility? _____

What is the patient's relationship to the subscriber?

☐ Self ☐ Spouse ☐ Child ☐ Other _____

Is the patient:
A full-time student? ..... ☐ No ☐ Yes
Physically or developmentally disabled? ..... ☐ No ☐ Yes

If the patient received the care outside the United States of America, what is the name of the country?

2. WHO IS THE SUBSCRIBER? (PERSON NAMED ON PREMERA BLUE CROSS CARD)

Name (First—Middle—Last)

Identification Number (Please copy from your ID card)

☐☐☐☐☐☐☐☐☐☐ - ☐☐

Employer

Group Number (please copy from your ID card)

Subscriber is
☐ Actively employed
☐ Retired

Present Home Address (Street number and address or rural route, city, town or post office, state and ZIP code)

☐ Check here if this is a new address

Telephone Numbers
Daytime ( )
Evening ( )

3. PLEASE ANSWER THE FOLLOWING QUESTIONS.

A. Payment information: Have these charges been paid in full? ☐ No ☐ Yes

B. Does the patient have other medical (other than Medicare), dental or vision coverage? ☐ No ☐ Yes If "Yes," what is the:

Subscriber's Name Identification Number (usually the social security number) Birthdate / / (Month/Day/Year)

Employer's Name Address Phone No. Group No.

Other Insurance Co. Name Address Phone No.

Other insurance covers: ☐ Medical ☐ Dental ☐ Vision

C. If covered by Medicare, check the type of Medicare coverage the patient has ☐ Part A (Hospital) ☐ Part B (Medical)

On what date did this Medicare coverage go into effect? Part A_____/_____/_____ Part B_____/_____/_____

What is the Medicare identification number? ☐☐☐☐☐☐☐☐☐☐

D. Did the condition result from an accident? ☐ No ☐ Yes If "Yes," complete ACCIDENT INFORMATION on PAGE 2.

E. Have you been treated for this condition before? ☐ No ☐ Yes If "Yes," list dates treated _____/_____/_____/_____/_____

F. What was the exact date the condition started? (Month/Day/Year) _____/_____/_____

G. Is this expense pregnancy related? ☐ No ☐ Yes If "Yes," what was the date of conception? _____/_____/_____

H. In what setting were these services performed?

☐ Inpatient Hospital ☐ Outpatient Hospital ☐ Office/Clinic ☐ Surgery Center ☐ Skilled Nursing Facility ☐ Home

☐ Other _____

An Independent Licensee of the Blue Cross Blue Shield Association

An **itemized bill** is a form the provider uses that details the services received by member and the cost of each service. It is not a statement which shows only the balance due.

Complete a separate claim form for each provider of service, such as doctor or laboratory.
Please do not use for more than one provider or patient.

4. FOR DENTAL CLAIM (ITEMIZED BILL MUST BE ATTACHED)

A. Was the treatment for orthodontic care? ☐ No ☐ Yes

B. Did treatment include an artificial device(s) such as dentures, bridge(s), crown(s), etc.? ☐ No ☐ Yes

If "Yes," was the treatment to replace an existing artificial device?_____

If "Yes," please explain why the replacement was necessary and give the date (if known) of the last replacement. _____

_____

5. FOR VISION CLAIM (ITEMIZED BILL MUST BE ATTACHED)

If lenses were prescribed, what type? ☐ Single ☐ Bifocal ☐ Trifocal ☐ Contact ☐ Other (please specify)_____

6. FOR ALL OTHER CLAIMS — DOCTOR, CLINIC, LAB, ETC. (ITEMIZED BILL MUST BE ATTACHED)

What was the condition requiring treatment? (Diagnosis)

_____

_____

_____

_____

_____

☐ Check here if routine physical examination

Is the condition work related? ☐ No ☐ Yes

Has the patient or will the patient file a workers' compensation claim? ☐ No ☐ Yes

Is this a second surgical opinion? ☐ No ☐ Yes

Is this a third surgical opinion? ☐ No ☐ Yes

Surgical procedure _____

_____

_____

_____

_____

_____

ACCIDENT INFORMATION

Was the reason for treatment due to an accident? ☐ No ☐ Yes

Where did the accident occur?
☐ At work ☐ At home ☐ Auto ☐ Other _____

What was the exact date of the accident/injury? _____/_____/_____
(Month / Day / Year)

If auto accident, do you have:

Personal injury protection? ☐ No ☐ Yes

Uninsured or underinsured coverage? ☐ No ☐ Yes

Medical payment coverage? ☐ No ☐ Yes

Name and address of auto insurance company:

_____

_____

_____

_____

_____

Do you intend to make a claim against a third party? ☐ No ☐ Yes

A person who knowingly and with intent to injure, defraud or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

X _____ /_____/_____

Subscriber's signature Date (Month/Day/Year)

To be accepted, this form must be fully completed, signed, and have proper bills attached.