

# Subscriber Claim Form

## Instructions for Submitting Claims

1. Submit a claim only when you are billed for services from a provider that does not directly submit a claim to the local Blue Cross Blue Shield plan.
2. Submit a separate form for each patient.
3. Attach an **original** itemized bill from your provider (**required information and example on the back**)
4. Keep a copy of all bills and claim forms submitted (originals will not be returned)
5. Be sure to sign and date the completed form.
6. Mail claim form and all attachments to **BCBSMA, P.O. Box 986030, Boston, MA 02298**

## Subscriber Information

|                                                |                 |            |                |
|------------------------------------------------|-----------------|------------|----------------|
| Identification Number (including alpha prefix) | Last Name       | First Name | Middle Initial |
| Address-Number & Street                        | City            | State      | Zip Code       |
| Date of Birth (MM/DD/YY)                       | Employer's Name |            |                |

## Patient Information

|                                                                             |                                                                                                                                                                                                                              |                |                          |
|-----------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|--------------------------|
| Patient Last Name                                                           | First Name                                                                                                                                                                                                                   | Middle Initial | Date of Birth (MM/DD/YY) |
| Gender:<br><input type="checkbox"/> Male<br><input type="checkbox"/> Female | Patient is:<br><input type="checkbox"/> Subscriber (contract holder) <input type="checkbox"/> Spouse (to contract holder)<br><input type="checkbox"/> Dependent (25 or under) <input type="checkbox"/> Other (specify) _____ |                |                          |

Does the patient have other insurance:    ☐ Yes ☐ No

Effective Date: \_\_\_\_\_

Medicare Part A (Hospital)    ☐ Yes ☐ No \_\_\_\_/\_\_\_\_/\_\_\_\_

Medicare Part B (Medical)    ☐ Yes ☐ No \_\_\_\_/\_\_\_\_/\_\_\_\_

Medicare Part A (Pharmacy)    ☐ Yes ☐ No \_\_\_\_/\_\_\_\_/\_\_\_\_

Other Blue Cross Blue Shield Membership?    ☐ Yes ☐ No \_\_\_\_/\_\_\_\_/\_\_\_\_

Other Insurance Plan?    ☐ Yes ☐ No \_\_\_\_/\_\_\_\_/\_\_\_\_

Identification Number: \_\_\_\_\_

Name and address of other insurance:  
\_\_\_\_\_

Was treatment for:

Accident at work? ☐ Yes ☐ No

Date of accident \_\_\_\_/\_\_\_\_/\_\_\_\_

Auto accident?    ☐ Yes ☐ No

Date of accident \_\_\_\_/\_\_\_\_/\_\_\_\_

If yes, name of auto insurance:  
\_\_\_\_\_

Policy Number: \_\_\_\_\_

Other accident?    ☐ Yes ☐ No

Date of accident \_\_\_\_/\_\_\_\_/\_\_\_\_

Subscriber Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Please allow up to 30 days for your claim to process.

### Example of a Complete Itemized Bill

|                                                                            |                                                              |
|----------------------------------------------------------------------------|--------------------------------------------------------------|
| Smith Speech Center<br>123 Main St.<br>Boston, MA 12345                    |                                                              |
| To: Joe Smith<br>15 Elm St.<br>Anytown, MA 12345                           | Patient Name: Joan Smith<br>Referring Doctor: Dr. John Jones |
| Jane Johnson, SLP, CCC<br>Speech-Language Pathologist<br>License # Y777777 | ← <b>Provider Credentials</b><br>NPI: 99-9999999             |

| Procedure Code(s)               | Units | Procedure Description   | Date of Service | Amount                            |
|---------------------------------|-------|-------------------------|-----------------|-----------------------------------|
| 92507                           | 1     | Speech–Language Therapy | 10/5/2008       | \$72.50 ← <b>Itemized Charges</b> |
| 92507                           | 2     | Speech–Language Therapy | 11/3/2008       | \$145.00                          |
| Diagnosis Codes: 784.50, 315.31 |       |                         |                 | <b>Total:</b> \$290.00            |
|                                 |       |                         |                 | <b>Payments:</b> \$290.00         |
|                                 |       |                         |                 | <b>Balance Due:</b> \$0.00        |

Please note that your bill does not need to look exactly like the example above, but **MUST** contain the following required information:

1. A letterhead from the provider that **MUST** include all of the following:
  - Provider name
  - Provider address
  - Provider NPI or License Number
  - Provider credentials, i.e., the initials associated with the educational degrees the provider has earned. Examples include: MD, LICSW, DC, PT, OT, ST
2. Patient's name
3. Date(s) of service
4. Itemized charges for each date of service and type of service received
5. Procedure codes (HCPCS/Revenue codes) for all services received
6. Diagnosis code(s) for services received
7. Number of Units-this is the number of times a service was performed on a particular date of service. This is required for occupational, physical & speech therapies, anesthesia and chiropractic services.
8. Attach any related claim summaries or Explanation of Medicare Benefit Forms you may have received for these services, including those received from other insurance companies.
9. When submitting a claim for **PRESCRIPTION DRUGS**, you must submit an itemized receipt from your pharmacy that includes:
  - National Drug Code (NDC)
  - Name of drug
  - Date dispensed
  - Quantity dispensed
  - Name of prescribing physician

To view processed claims, visit our website <http://www.bluecrossma.com/wps/portal/members/>. If you have not already registered for **Member Central**, click **Create an Account** and follow the directions.

Blue Cross Blue Shield of Massachusetts complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation or gender identity.

ATTENTION: If you don't speak English, language assistance services, free of charge, are available to you. Call Member Services at the number on your ID Card (TTY: **711**).

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia con el idioma. Llame al número de Servicio al Cliente que figura en su tarjeta de identificación (TTY: **711**).

ATENÇÃO: Se fala português, são-lhe disponibilizados gratuitamente serviços de assistência de idiomas. Telefone para os Serviços aos Membros, através do número no seu cartão ID (TTY: **711**).

