BlueCross BlueShield of North Carolina

MEMBER CLAIM FORM

MAIL TO: BCBSNC, PO BOX 35, DURHAM, NC 27702-0035

TIPS FOR FILING

- Claims must be filed within 6 months from the date services were received or they will be denied for late filing.
- Complete a separate claim form for each covered family member.
- Type or print legibly.
- Enclose receipts and make copies for your records.
- **Do not file prescription drugs on this form. See the back of the form for filing information.**
- Do not file a claim if the Provider or Hospital is filing for the same services.
- Attach Explanation of Benefits if these services are covered by another group health policy.

SECTION I: PATIENT INFORMATION

SUBSCRIBER NUMBER

BEGIN WITH 3 ALPHA PREFIX

2 DIGITS PRECEDING PATIENT'S NAME *(Please see ID card)*

PATIENT LAST NAME | FIRST NAME | MI

PATIENT DATE OF BIRTH

PATIENT SEX ☐ MALE ☐ FEMALE

PATIENT RELATIONSHIP TO SUBSCRIBER

☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER _____

SECTION II: SUBSCRIBER INFORMATION

SUBSCRIBER NAME

ADDRESS

(LINE 1)

(LINE 2)

CITY | STATE | ZIP CODE

☐ ***PLEASE CHECK HERE IF ADDRESS HAS CHANGED***

SECTION III: OTHER INSURANCE INFORMATION

PLEASE COMPLETE THE INFORMATION BELOW IF THE PATIENT IS COVERED BY ANOTHER GROUP HEALTH INSURANCE.

Does the patient have other insurance? ☐ YES ☐ NO

OTHER HEALTH INSURANCE COMPANY NAME

OTHER POLICY NUMBER

OTHER POLICY HOLDER'S NAME

OTHER POLICY HOLDER'S EMPLOYER NAME

PLEASE COMPLETE THE INFORMATION BELOW IF THE PATIENT IS COVERED BY MEDICARE:

MEDICARE HEALTH INSURANCE CLAIM NUMBER

IS PATIENT ELIGIBLE FOR: ☐ PART A ☐ PART B ☐ PART A AND B

PLEASE NOTE: IF YOUR OTHER INSURANCE OR MEDICARE POLICY IS PRIMARY, PLEASE ATTACH A COPY OF THE EXPLANATION OF BENEFITS. YOUR CLAIM CANNOT BE PROCESSED WITHOUT THIS INFORMATION.

I certify that the information on this form is correct and the expenses incurred were necessary for the services filed.

SUBSCRIBER SIGNATURE | DATE | TELEPHONE NUMBER WE CAN CONTACT YOU *(if necessary)*

Please use the reverse side of this form to provide description of services you are filing for.

SECTION IV: OTHER SERVICES AND SUPPLIES NOT FILED BY PROVIDER OR HOSPITAL
(Attach a copy of a super bill or itemized receipts)

THESE MAY INCLUDE OFFICE VISITS, HOSPITAL VISITS, PHYSICAL THERAPY, AMBULANCE, APPLIANCES, ETC.

☐ If services were rendered outside the USA, please indicate: **COUNTRY:** _____ **CURRENCY USED:** _____

DATE OF SERVICE *(MM/DD/YY)*	DESCRIPTION OF SERVICE / SUPPLIES	DIAGNOSIS OR SYMPTOMS YOU SOUGHT TREATMENT FOR	CHARGE
01-05-99	EXAMPLE Office Visit	Cold and Flu Symptoms	$54.00

SECTION V: PRIVATE DUTY NURSING
(Refer to Member Booklet "Who Do I Call" Section)

IF YOUR COVERAGE REQUIRES CERTIFICATION OF PRIVATE DUTY NURSING SERVICES, YOU OR YOUR PROVIDER SHOULD CALL IN ADVANCE OF SERVICES.

ENCLOSE A COPY OF YOUR RECEIPTS FOR THESE SERVICES.

DATE OF SERVICE *(MM/DD/YY)*	NAME OF NURSE	INDICATE RN OR LPN	LICENSE NUMBER	HOURS WORKED	CHARGE
01-05-99	EXAMPLE Ms. Jane M. Doe	LPN	123456	8	$160.00

If you have purchased prescription drugs and they are not being filed for you, please complete the Prescription Drug Claim Form and mail to:

PAID PRESCRIPTIONS, L.L.C.
PO BOX 307
LEE'S SUMMIT, MO 64063-2187

Claim forms can be requested from our website ww.bcbsnc.com or by calling customer service at the toll free number on your ID card.