



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 & 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: <input type="checkbox"/> Male <input type="checkbox"/> Female	Patient is: <input type="checkbox"/> Subscriber (contract holder) <input type="checkbox"/> Spouse (to contract holder) <input type="checkbox"/> Child (age 18 or younger) <input type="checkbox"/> Student (age 19 or older) <input type="checkbox"/> Handicapped Dependent (age 19 or older) <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
123 Main St.
Boston, MA 12345

To: Joe Smith
15 Elm St.
Anytown, MA 12345

Patient Name: Joan Smith
Referring Doctor: Dr. John Jones

Jane Johnson, SLP, CCC ← **Provider
Credentials**
Speech-Language Pathologist
License # Y777777

Tax ID/NPI: 99-9999999

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

