[redacted]

MASTER MEDICAL CLAIM FORM

Blue Cross Blue Shield of Michigan

an independent licensee of the Blue Cross and Blue Shield Association.

CL

INSTRUCTIONS FOR FILING A CLAIM – PLEASE TYPE OR PRINT USING BLACK INK

- FOR EACH ELIGIBLE FAMILY MEMBER, DEPENDENT OR SPOUSE SEPARATE ALL ITEMIZED BILL(S), RECEIPTS(S), COPIES OF EXPLANATION OF BENEFITS FORMS OR CHECK VOUCHERS.
- BOXES 1THROUGH 15 **MUST** BE COMPLETED.
- IF YOU ANSWER "YES" TO BOX NUMBER **14**, PLEASE COMPLETE BOXES **16** THOUGH **24**.
- **COMPLETE A SEPARATE CLAIM FORM FOR EACH ELIGIBLE MEMBER. NOTE: ONLY ONE CLAIM FORM PER MEMBER IS NEEDED REGARDLESS OF THE NUMBER OF RECEIPTS.**
- STAPLE OR PAPERCLIP EACH MEMBER'S ITEMIZED BILL(S) OR RECEIPTS(S) TO HIS/HER COMPLETED CLAIM FORM(S).
- ALL COMPUTERIZED RECEIPTS SUBMITTED MUST INCLUDE THE PROVIDER SIGNATURE AND PROVIDER CODE.
- IF APPLICABLE, ATTACH COPIES OF YOUR EXPLANATION OF MEDICARE BENEFITS FORM OR MEDICARE VOUCHER.
- PLEASE DO NOT PEEL AND STICK RECEIPTS TO THE CLAIM FORM.
- SAVE COPIES OF ALL ITEMS SUBMITTED.
- CLAIM FORM **MUST** BE SIGNED BY THE SUBSCRIBER (CONTRACT HOLDER, BOX NUMBER 15).
- CASH REGISTER RECEIPTS, CANCELLED CHECKS, MONEY ORDER RECEIPTS, UNSIGNED COMPUTERIZED RECEIPTS OR STATEMENTS AND PERSONAL ITEMIZATIONS ARE NOT ACCEPTABLE AND IF SUBMITTED BECOME THE PROPERTY OF BCBSM.

NOTE: FOR BEST SERVICE, PLEASE SUBMIT YOUR MASTER MEDICAL CLAIMS TO US AS SERVICES OCCUR.

SUBSCRIBER INFORMATION

1. SUBSCRIBER'S LAST NAME

2. SUBSCRIBER'S FIRST NAME

3. STREET ADDRESS ☐ **CHECK HERE IF NEW ADDRESS**

CITY

STATE | ZIP CODE

4. SUBSCRIBER'S SOCIAL SECURITY NUMBER IS THE SAME AS BCBSM CONTRACT NUMBER ➢

SUBSCRIBER'S CONTRACT NUMBER

5. THIS INFORMATION CAN BE TAKEN FROM YOUR BCBSM I.D. CARD ➢

BCBSM GROUP NO.

PATIENT INFORMATION

6. PATIENT'S LAST NAME

7. PATIENT'S FIRST NAME

8. PATIENT'S DATE OF BIRTH ➢ MO. DAY YR.

9. PATIENT'S RELATIONSHIP TO SUBSCRIBER: ❑ SELF ❑ SPOUSE ❑ DEPENDENT

10. PATIENT SEX: ❑ M ❑ F

11. ACCIDENT: ❑ YES ❑ NO

12. IF YES, GIVE DATE OF ACCIDENT: MO. DAY YR.

FOR BCBSM USE ONLY

13. WORKER'S COMPENSATION?: ❑ YES ❑ NO

14. OTHER HEALTH CARE COVERAGE?: ❑ YES ❑ NO **IF YES, COMPLETE BOXES 16 THROUGH 24.**

OTHER CARRIER INFORMATION

16. OTHER POLICY HOLDER'S LAST NAME

17. OTHER POLICY HOLDER'S FIRST NAME

18. OTHER POLICY HOLDER'S SOC. SEC. NUMBER

19. OTHER POLICY HOLDER'S DATE OF BIRTH ➢ MO. DAY YR.

20. NAME OF OTHER HEALTH CARRIER

21. OTHER CARRIER POLICY/GROUP NUMBER

22. OTHER CARRIER STREET ADDRESS

CITY | STATE | ZIP CODE

23. OTHER EMPLOYER NAME

24. TYPE OF OTHER HEALTH CARE COVERAGE: ❑ MAJOR MEDICAL ❑ DENTAL ❑ VISION ❑ PRESCRIPTION DRUGS ❑ HOSPITAL/ PHYSCIAN ❑ OTHER

CERTIFICATION STATEMENT

I CERTIFY THAT THE ABOVE INFOMRATION IS TRUE AND THE ATTACHED MATERIAL IS CORRECT AND UNALTERED AND THAT THE EXPENSES WERE INCURRED BY THE ABOVE NAMED PATIENT. I UNDERSTAND ALL MATERIAL SUBMITTED BECOMES THE PROPERTY OF BLUE CROSS AND BLUE SHIELD OF MICHIGAN AND MAY NOT BE RETURNED. I REALIZE FALSE RECEIPTS OR FRADULENT ALTERATIONS OF THESE MATERIALS WILL RESULT IN CIVIL OR CRIMINAL PROSECUTION. I AUTHORIZE THE RELAEASE OF ANY INFORMATION NECESSARY TO PROCESS OR REVIEW THIS CLAIM.

15. SUBSCRIBER'S SIGNATURE (REQUIRED):

DATE:

TELEPHONE NUMBER: ( )

CLAIM NUMBER (FOR BCBSM USE ONLY)

YOUR RIGHT TO CONFIDENTIALITY

WE WILL NOT RELEASE ANY INFORMATION ABOUT YOU EXCEPT: 1) WHEN YOU ASK US TO IN WRITING, OR 2) WHEN RELEASE (TO ANOTHER INSURANCE COMPANY FOR EXAMPLE) IS NECESSARY TO PROCESS OR REVIEW A CLAIM. WE WILL TELL YOU WHICH INFORMATION WE RELEASED TO WHOM, IF YOU REQUEST IT.

NOTE: FOR REIMBURSEMENT OF MASTER MEDICAL CLAIMS ONLY, MAIL TO :
ATTN: MASTER MEDICAL DEPARTMENT, M.C. B550
BLUE CROSS AND BLUE SHIELD OF MICHIGAN
P.O. BOX 172
DETROIT, MICHIGAN 48231-0172