Letter (F6-4)

BlueCross BlueShield
of Western New York
A Division of HealthNow New York Inc. An Independent Licensee of the BlueCross BlueShield Association

P.O. Box 80
Buffalo, NY 14240-0080

MEDICAL BENEFITS
SUBSCRIBER CLAIM FORM

*** MAIL COMPLETED FORM TOGETHER WITH ALL ITEMIZED BILLS TO ADDRESS SHOWN ABOVE.

IF CLAIM FORM IS NOT COMPLETE OR IF ANY OF THE ITEMIZED BILLS REQUIRE FURTHER INFORMATION, SUCH MATERIAL MAY BE RETURNED TO YOU WITH ADDITIONAL INSTRUCTIONS.
OTHERWISE ALL ITEMIZED BILLS WILL BE RETAINED BY US AND CANNOT BE RETURNED.

ALL QUESTIONS MUST BE ANSWERED. PLEASE PRINT OR TYPE.

ENTER NAMES AS SHOWN ON YOUR BLUECROSS BLUESHIELD IDENTIFICATION CARD.

1

SUBSCRIBER'S LAST NAME	FIRST NAME	INITIAL	BLUECROSS BLUESHIELD ID. NO.	GROUP NUMBER

ADDRESS-NUMBER AND STREET	Please Check Here If This Is A New Address ☐	CITY	STATE	ZIP CODE

Fold

2

PATIENT'S LAST NAME	FIRST NAME	INITIAL	DATE OF BIRTH MONTH DAY YEAR	SEX ☐ MALE ☐ FEMALE	PATIENT'S RELATIONSHIP TO SUBSCRIBER ☐ SELF ☐ CHILD ☐ SPOUSE

3

OTHER HEALTH INSURANCE COVERAGE:

DOES PATIENT HAVE ADDITIONAL HEALTH INSURANCE COVERAGE THROUGH EMPLOYER OR OTHER GROUP HEALTH INSURANCE? ☐ YES ☐ NO **IF YES,** PLEASE COMPLETE.

NAME OF OTHER POLICY HOLDER	POLICY OR IDENTIFICATION NUMBER

POLICY EFFECTIVE DATE	TYPE OF COVERAGE ☐ SINGLE ☐ FAMILY	OTHER POLICY HOLDER'S BIRTH DATE

NAME AND ADDRESS OF OTHER INSURANCE CARRIER

Fold

4

MEDICARE COVERAGE: IS THE PATIENT ENTITLED TO MEDICARE? ☐ YES ☐ NO **IF YES,** PLEASE COMPLETE.

PATIENT'S MEDICARE IDENTIFICATION NUMBER _____

MEDICARE PART A (HOSPITAL INSURANCE) EFFECTIVE DATE _____

MEDICARE PART B (MEDICAL INSURANCE) EFFECTIVE DATE _____

IS THE PATIENT EMPLOYED? ☐ YES ☐ NO IS THE SPOUSE EMPLOYED? ☐ YES ☐ NO

5

WERE EXPENSES DUE TO AN ACCIDENTAL INJURY: ☐ YES ☐ NO **IF YES,** PLEASE COMPLETE.

TYPE OF ACCIDENT: ☐ WORK ☐ AUTO ☐ MOTORCYCLE ☐ OTHER DATE OF ACCIDENT _____

SUBSCRIBER'S SIGNATURE AND ITEMIZATION OF BILLS REQUIRED ON THE OTHER SIDE.

EXPENSE ITEMIZATION

ITEMIZED BILLS FOR **SERVICE OR SUPPLIES MUST BE ATTACHED TO THIS FORM** WITH THE FOLLOWING INFORMATION INDICATED:

1. PATIENT'S FULL NAME.
2. AMOUNT CHARGED FOR EACH SERVICE OR SUPPLY.
3. DATE EACH SERVICE OR SUPPLY WAS RENDERED.
4. DESCRIPTION OF EACH SERVICE OR SUPPLY.
5. DIAGNOSIS OR NATURE OF ILLNESS FOR EACH SERVICE.
6. NAME AND ADDRESS OF PROVIDER/SUPPLIER.
7. DRUG/MEDICINE BILLS MUST CONTAIN PRESCRIPTION NUMBER AND NAME OF PRESCRIBING PHYSICIAN.

NOTE: CANCELLED CHECKS OR CASH REGISTER TAPES ARE NOT ACCEPTABLE.

IN ADDITION: IF YOU HAVE RECEIVED ANY PAYMENT OR REJECTION NOTICES FROM BLUECROSS BLUESHIELD OR MEDICARE FOR THOSE EXPENSES BEING REPORTED, PLEASE ATTACH THEM.

6

LIST BELOW THOSE SERVICES OR SUPPLIES FOR WHICH YOU ARE REQUESTING PAYMENT

DATE OF SERVICE	DESCRIBE: SERVICES OR SUPPLIES	DIAGNOSIS OR DESCRIPTION OF ILLNESS OR INJURY	DIAGNOSIS / PROCEDURE CODE (FROM BILL OR RECEIPT)	CHARGES

DX	FOR BLUECROSS BLUESHIELD OFFICE USE ONLY				
a.	b.	c.	d.	e.	

7 ENTER TOTAL CHARGES HERE

PLEASE REMEMBER TO ATTACH YOUR ITEMIZED BILLS AND SIGN THIS CLAIM FORM.

IMPORTANT NOTICE:

"ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION."

SUBSCRIBER'S SIGNATURE (MUST BE SIGNED) _____ DATE _____ HOME PHONE NUMBER _____