

## **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

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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:	Patient is:								
☐ Male ☐ Female	□ Subscriber (contract holder) □ Spouse (to contract holder) □ Child (age 18 or younger) □ Student (age 19 or older) □ Handicapped Dependent (age 19 or older) □ Other (specify) □								
Does the pati	ent have other	insurance: ☐ Yes ☐ No	Was treatment for	Was treatment for:					
Effective Date:			: Accident at work	Accident at work? ☐ Yes ☐ No					
Medicare Part A (Hospital)			Date of accident	Date of accident/					
Medicare Part B (Medical) ☐ Yes ☐ No//			Auto accident?	Auto accident? ☐ Yes ☐ No					
Medicare Part D (Pharmacy) ☐ Yes ☐ No//_			Date of accident	Date of accident/					
Other Blue Cross Blue Shield Membership?			If yes, name of a	uto insurance:					
Other Insurance Plan?			Policy Number:						
Identification Number:				Other accident?					
Name and address of other insurance:				Date of accident/					
Subscriber Signature:			Da	ite:					

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 Speech-Language Pathologist Credentials 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	<b>Total:</b> \$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.

