

MEMBER CLAIM FORM

Do not file prescription drugs on this form. Type or use blue or black ink to complete.

• Visit **bcbsnc.com** for prescription drug, dental and international claim forms, or call the toll-free number on your ID card.

Filing Requirements:

- Complete a separate claim form for each covered family member.
- Enclose itemized receipts and make copies for your records. See Section IV for required information.
- Do not file a claim if the provider is filing for the same services.
- Attach Explanation of Benefits if these services are covered by another insurance policy.
- Claims must be filed within 18 months from the date services were received, or they will be denied.
- Please see Section VI for mailing information.

Any claim filed without the required documentation listed above will be returned.

SECTION I: Patient Information		Please enter the subscriber number from your ID card.	
Subscriber Number:	Begin with letter prefix	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	2 digits preceding patient's name (see ID card)
Patient's Last Name: _____		First Name: _____ Middle Initial: _____	
Date of Birth:	<input type="text"/> - <input type="text"/> - <input type="text"/>	Sex:	<input type="checkbox"/> Male <input type="checkbox"/> Female
Relationship to Subscriber:		<input type="checkbox"/> Self <input type="checkbox"/> Child <input type="checkbox"/> Spouse <input type="checkbox"/> Other: _____	

SECTION II: Mailing Information	<input type="checkbox"/> Please check here if address has changed.
Subscriber Name: _____	
Address (Line 1): _____	
Address (Line 2): _____	
City: _____	State: NC ZIP Code: _____

SECTION III: Other Insurance Information	
Please complete the information below if the patient is covered by another health insurance policy.	
Does the patient have other insurance?	<input type="checkbox"/> Yes <input type="checkbox"/> 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: <input type="checkbox"/> Part A <input type="checkbox"/> Part B <input type="checkbox"/> Part A and B

PLEASE NOTE: If your other insurance or Medicare policy is primary, you must attach a copy of the Explanation of Benefits from that insurer. Your claim cannot be processed without this information.

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