

MEMBER CLAIM FORM

Please use a separate claim form for each patient and each provider of service (such as doctor or laboratory).

All information that is applicable to the claim being submitted must be completed. Leaving any applicable questions unanswered may cause your claim to be returned and processing to be delayed until the information is completed.

When you've answered all the questions below, turn the form over and complete the section of page 2 that applies to your claim.

Do not use this form for prescription reimbursement. Please use the Prescription Drug Reimbursement Form for primary prescription claim submission and the Secondary Insurance Prescription Drug Claim Form for secondary prescription claim submission. (Call the Customer Service number listed on the back of your ID card for the proper form.)

1. WHO IS THE PATIENT?

Name (First—Middle—Last) _____

What is the patient's relationship to the subscriber?

Self Spouse Child Other _____

Gender Birthdate (Month/Day/Year)

Male Female

____/____/____

Is the patient:

A full-time student? No Yes

Physically or developmentally disabled? No Yes

If the patient is a dependent child of divorced parents, who has legal custody? Mother Father _____

If the patient received the care outside the United States of America, what is the name of the country?

Who has financial responsibility under the divorce decree? _____

2. WHO IS THE SUBSCRIBER? (PERSON IN WHOSE NAME COVERAGE WITH PREMERA BLUE CROSS BLUE SHIELD OF ALASKA IS ESTABLISHED)

Name (First—Middle—Last) _____

Prefix and Identification # (Please copy from your ID card)

Employer _____

Group Number
(please copy from your ID card)

Subscriber is
 Actively employed
 Retired Laid off

Mailing Address _____

Check here if this is a new address

Telephone Numbers
Daytime () _____
Evening () _____

3. PLEASE ANSWER THE FOLLOWING QUESTIONS.

A. Payment information: Have these charges been paid in full? No Yes, please attach proof of payment in full with claim submission.

B. Does the patient have other medical (other than Medicare), dental or vision coverage? No Yes If "Yes," what is the: _____

Subscriber's Name Identification Number Birthdate
____/____/____ (Month/Day/Year)

Employer's Name Address Phone No. Group No.

Other Insurance Co. Name Address Phone No.

Other insurance covers: Medical Dental Vision

C. If covered by Medicare, check the type of Medicare coverage the patient has and enter the date this coverage went into effect.

Part A (Hospital) ____/____/____ Part B (Medical) ____/____/____ Part D (Rx) ____/____/____

Reason (check all that apply): Age Disability End Stage Renal Disease Name of Part D Carrier: _____

What is the Medicare identification number (must complete)?

What is the patient's Social Security number (must complete)? - -

D. Did the condition result from an accident? No Yes If "Yes," complete ACCIDENT INFORMATION on PAGE 2.

E. Have you been treated for this condition before? No Yes If "Yes," list dates treated ____/____/____

F. What was the exact date the condition started? (Month/Day/Year) ____/____/____

G. Is this expense pregnancy-related? No Yes If "Yes," what was the date of conception? ____/____/____

H. In what setting were these services performed?

Inpatient Hospital Outpatient Hospital Office/Clinic Surgery Center Skilled Nursing Facility Home
 Other _____

An **itemized bill** is a form the provider uses that details the services received by the member and the cost of each service. It is not a statement which shows only the balance due. Please do not highlight or modify receipts as this may cause delayed processing of your claim.

Complete a separate claim form for each provider of service, such as doctor or laboratory.

Please do not use for more than one provider or patient.

4. FOR DENTAL CLAIM (ITEMIZED BILL MUST BE ATTACHED)

A. Was the treatment for orthodontic care? No Yes

B. Did treatment include an artificial device(s) such as dentures, bridge(s), crown(s), etc.? No Yes

If "Yes," was the treatment to replace an existing artificial device? _____

If "Yes," please explain why the replacement was necessary and give the date (if known) of the last replacement. _____

5. FOR VISION CLAIM (ITEMIZED BILL MUST BE ATTACHED)

If lenses were prescribed, what type? Single Bifocal Trifocal Contact Other (please specify) _____

6. FOR ALL OTHER CLAIMS — DOCTOR, CLINIC, LAB, ETC. (ITEMIZED BILL MUST BE ATTACHED)

What was the condition requiring treatment? (Diagnosis)

Check here if routine physical examination

Is the condition work related? No Yes

Has the patient or will the patient file a workers' compensation claim? No Yes

Is this a second surgical opinion? No Yes

Is this a third surgical opinion? No Yes

Surgical procedure _____

ACCIDENT INFORMATION

Was the reason for treatment due to an accident? No Yes

Where did the accident occur?
 At work At home Auto Other _____

What was the exact date of the accident/injury? _____ / _____ / _____
(Month / Day / Year)

If auto accident, do you have:

Personal injury protection? No Yes

Uninsured or underinsured coverage? No Yes

Medical payment coverage? No Yes

Name and address of auto insurance company:

Do you intend to make a claim against a third party? No Yes

A person who knowingly and with intent to injure, defraud or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

X

Patient's signature (or legal guardian if patient cannot legally consent to services)

Date (Month/Day/Year)

To be accepted, this form must be fully completed (as applicable to the claim being submitted), signed, and have proper bills attached.

Mail to: Premera Blue Cross Blue Shield of Alaska
P.O. Box 240609
Anchorage, AK 99524-0609