



Medex[®] Subscriber Claim Form

MASSACHUSETTS

Please read the instructions on the reverse side of this form and print clearly in the required boxes. **NOTE:** This should not be used to submit a drug claim if you are a direct-pay member. Instead, please fill out a separate MEDEX DRUG CLAIM FORM.

Medex Identification Number									

↑ **Important: Take this number from your Medex ID Card. Include first three letters.** ↑

Part I

Last Name	First	M.I.	Prefix	Medicare Number
Street Address				Date of Birth (MM/DD/YY)
City	State	Zip Code	<input type="checkbox"/> Male <input type="checkbox"/> Female	

Part II: Please Give the Dates of Your Most Recent Hospitalization

Hospital's Name				Admission Date (MM/DD/YY)
Street Address	City	State	Zip Code	Discharge Date (MM/DD/YY)

Part III: Claim Information (Attach Itemized Bills)

Type of Service	Provider Name and Address	Diagnosis or Illness	Date of Service (MM/DD/YY)	Amount Charged	Office Use Only

Part IV

Total Number of Bills Attached: _____	Total Charges: \$ _____
<input type="checkbox"/> Pay Subscriber <input type="checkbox"/> Pay Provider	

See Reverse: Please Date and Sign Your Name in the Space Provided

Instructions

Attach the Medicare Explanation of Benefits for all hospital and physician claims.

Submit claims to:

Blue Cross Blue Shield of Massachusetts
P.O. Box 986030
Boston, MA 02298

Note: For services rendered OUTSIDE OF THE US, please go to the following website:
www.bcbsglobalcore.com

Claim Checklist

Please review this checklist before sending your claim to us. Incomplete forms may be returned to you.

- Have you listed your Medex Identification Number in the space provided?
- Have you listed a diagnosis or illness on each line of the claim information section?
- Have you listed the total charges for this claim?
- Have you attached all related Explanation of Benefits or Explanation of Medicare Benefits forms you may have received previously for these services?
- Have you signed and dated the completed claims form?
- Have you kept a copy of all receipts and EOB'S?

Certification and Authorization

I authorize the release of any information to Blue Cross and Blue Shield about my examination and treatment. I certify that the information provided in the support of this claim is complete and correct and that I have not been previously reimbursed for these services.

Subscriber's Signature

Date

