



# VISION

DO NOT WRITE IN THIS SPACE  
OFFICE USE ONLY

MASSACHUSETTS

SEE INSTRUCTIONS ON THE BACK OF THIS FORM.  
PLEASE PRINT ALL INFORMATION CLEARLY.

### SUBSCRIBER INFORMATION

Identification Number	Subscriber's Last Name	First Name	Middle Initial
Address-Number and Street		City	State
Zip Code			
Employer's Name			

### PATIENT INFORMATION (Use a separate form for each patient)

Patient's Last Name	First Name	Middle Initial	Mo	Day	Year
Sex 1. <input type="checkbox"/> Male 2. <input type="checkbox"/> Female	Patient Is: (Check one) 1. <input type="checkbox"/> Subscriber (Contract holder) 2. <input type="checkbox"/> Spouse (To contract holder)	3. <input type="checkbox"/> Child (Age 18 or younger) 4. <input type="checkbox"/> Handicapped Dependent (Age 19 or older) 5. <input type="checkbox"/> Student (Age 19 or older)	6. <input type="checkbox"/> Stepchild 7. <input type="checkbox"/> Other (Specify) .....		

PATIENT ENROLLED IN: (If yes, give identification number and effective date)

Medicare Part A (Hospital)?  No  Yes  
 Medicare Part B (Medical)?  No  Yes  
 Other Blue Cross and Blue Shield membership?  No  Yes  
 Other insurance plan?  No  Yes

Identification number: .....  
 Effective date: .....

Name and address of other insurance: .....

WAS TREATMENT FOR:

1. Accident at work?  No  Yes Date of Accident: MO DAY YR

2. Auto accident?  No  Yes Date of Accident: MO DAY YR

If yes, give name of auto insurance: .....

Policy number: .....

### CLAIM INFORMATION (Attach itemized bills to section noted below.)

	TYPE OF SERVICE	PROVIDER NAME	DIAGNOSIS	Date of Service			AMOUNT CHARGED	OFFICE USE ONLY
				MO	DAY	YR		
A								
T								
T								
A								
C								
H								
O								
R								
I								
G								
I								
N								
A								
L								
B								
I								
L								
L								
S								
H								
E								
R								
E								

TOTAL NUMBER OF BILLS ATTACHED: \_\_\_\_\_ TOTAL CHARGES: \$ \_\_\_\_\_

### CERTIFICATION AND AUTHORIZATION (This form must be signed and dated)

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 support of this claim is complete and correct and that I have not been previously reimbursed for these services.

Subscriber's Signature: ..... Date: .....

## **INSTRUCTIONS**

File this form when you receive a bill for services for which the provider does not directly submit a claim to Blue Cross and Blue Shield of Massachusetts.

When filing a claim, please be sure to:

1. Complete a separate form for each patient.
2. Answer all questions on this form and complete claim checklist below.
3. Attach original itemized bills which include:

Patient's name  
Date(s) of service  
Type(s) of service  
Individual charges for each date and type of service rendered  
Name and address of provider of service  
Diagnosis

Additionally, drug receipts must indicate:

Prescription number(s)  
Name of drug  
Quantity dispensed  
Name of prescribing physician

4. Include only one service on each line.

**NOTE: PLEASE KEEP COPIES OF YOUR BILLS PRIOR TO SENDING THE ORIGINALS WITH THIS CLAIM, SERVICES THAT ARE DENIED FOR PAYMENT WILL BE NOTED ON YOUR CLAIM SUMMARY. WE DO NOT RETURN ANY BILLS TO YOU EVEN IF THEY ARE DENIED FOR PAYMENT.**

5. Attach all related Claim Summary or Explanation of Medicare Benefits forms you may have received previously on these services.
6. Sign and date the completed form.
7. MAIL THIS FORM TO:

**NATIONAL CLAIMS DEPARTMENT  
BLUE CROSS AND BLUE SHIELD OF MASSACHUSETTS  
P.O. BOX 986030  
BOSTON, MA 02298**

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### **CLAIM CHECKLIST**

**PLEASE REVIEW THIS CHECKLIST BEFORE SENDING YOUR CLAIM TO US.  
INCOMPLETE FORMS MAY BE RETURNED TO YOU.**

- Have you listed your Blue Cross and Blue Shield 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 original itemized bills?
- Have you attached all related Claim Summary or Explanation of Medicare Benefits forms you may have received previously on these services?
- Have you signed and dated the completed claim form?