MEDEX® SUBSCRIBER MEDICAL CLAIM FORM

Instructions

- Submit a claim only when you're billed for services from a provider that doesn't directly submit a claim to the local Blue Cross Blue Shield plan.
- Use reverse side or another sheet of paper to include any additional information if necessary.
- Please include proof of payment and itemized bill from provider.
- Keep a copy of all bills and claim forms submitted (originals won't be returned)
- For services rendered OUTSIDE OF THE U.S, visit **bcbsglobalcore.com**.

Subscriber information

Last name:	First name:	Middle initial:

Cardholder identification number: (including prefix)	Date of birth: (mm/dd/yyyy)
Address:	Phone number:

Provider and service information

Name of provider:	Dates of service(s): (mm/dd/yyyy)
Phone number and address of provider:	Provider NPI number:

In what setting did you receive treatment? (Examples: office, emergency room, hospital, clinic, etc.)

What was your reason for seeking treatment? (Examples: asthma, diabetes, chest pains, etc.)

Total charges for all services: $	Amount of reimbursement you're requesting: $

Describe the items or services that were received. (Examples: emergency room visit, flu shot, eyewear, durable medical equipment, hearing aid, etc.)

(Continued)

Blue Cross Blue Shield of Massachusetts is an Independent Licensee of the Blue Cross and Blue Shield Association.

Check which of the following acceptable proof of payment you're attaching to this form:

- ☐ A copy of the front and back of the canceled check written to the provider with itemized bill
- ☐ A credit card statement or receipt with itemized bill
- ☐ A statement from the provider, on the provider's letterhead

Please read this important information.

- When submitting claims for PRESCRIPTION DRUGS, use the Medex Prescription Drug Claim form located on our website at **medicare.bluecrossma.com**.
- Include your Medicare EOB
- If the provider of service opted out of Medicare, include a copy of the opt-out letter.

Signature is required:

Member signature: Date: (mm/dd/yyyy)

Reimbursement of submitted claims is subject to your health plan and not guaranteed. Reimbursement will be according to the parameters of your health plan. It will be only for the amount your program would have paid on your behalf. The amount of reimbursement may be significantly lower than the original amount you paid.

Mail completed form and documents to: Blue Cross Blue Shield of Massachusetts, P.O. Box 986030 Boston, MA 02298 or Fax: **617-246-8953**

To submit claims online, sign in to your MyBlue account. If you don't have a MyBlue account, register for one at **bluecrossma.org**.

Questions?

If you have any questions, call us at **1-800-258-2226** (TTY: **711**), Monday through Friday, from 8:00 a.m. to 6:00 p.m. ET.

Blue Cross Blue Shield of Massachusetts complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity.

ATTENTION: If you don't speak English, language assistance services, free of charge, are available to you. Call Member Service at the number on your ID card (TTY: **711**).

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia con el idioma. Llame al número de Servicio al Cliente que figura en su tarjeta de identificación (TTY: **711**).

ATENÇÃO: Se fala português, são-lhe disponibilizados gratuitamente serviços de assistência de idiomas. Telefone para os Serviços aos Membros, através do número no seu cartão ID (TTY: **711**).

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