MASSACHUSETTS

MEDICARE ADVANTAGE 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)
- Any member liability such as copay, co-insurance, or deductible may apply.

To submit claims online instead of a paper form, sign in to your MyBlue account. If you don't have a MyBlue account, create one at **bluecrossma.org**.

Subscriber information

Last name: First name: Middle initial:

Cardholder identification number: (including prefix) Birth date: (MM/DD/YYYY)

Address: Phone number:

Provider and service information

Name of provider: Dates of service(s):

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 are requesting:
$_____

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

Was treatment for:

Accident at work? Yes ❑ No ❑ Date of accident:

Other accident? Yes ❑ No ❑ Date of accident:

Auto accident ? Yes ❑ No ❑ Date of accident:

If yes, name of auto insurance:

Policy number:

(Continued)

Please complete the additional questions if services were performed outside of the USA:

In what country were services performed?

In what language was the bill/receipt written?

In what currency was the bill paid?

Itemized bills, receipts, and statements must be translated to English. If you need assistance with translating your documents, contact your local town hall or library. You can also contact Member Service at **1-800-200-4255** (TTY **711**) to help assist you with locating a Translation Center.

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

- ❑ A copy of the front and back of the canceled check written to the provider
- ❑ 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 **PART D PRESCRIPTION DRUGS**, please use the Prescription Drug Claim form located on our website at bluecrossma.com/medicare-options
- If services were provided for **VACCINES**, please use the Vaccine Claim form located on our website at bluecrossma.com/medicare-options
- To ask for a **PART D COVERAGE DETERMINATION**, please use the Medicare Prescription Drug Coverage Determination form located on our website at bluecrossma.com/medicare-options

Signature is required: Member signature: _____ Date: _____

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, Medicare Advantage Claims, P.O. Box 55007, Boston, MA 02205

To submit claims online instead of a paper form:
Sign in to your MyBlue account. If you don't have a MyBlue account, create one at **bluecrossma.org**.

Questions?

If you have any questions, please call us at **1-800-200-4255**, 8:00 a.m. to 8:00 p.m. ET, seven days a week except April 1 through September 30 when we are open Monday through Friday. TTY users should call **711**.

Blue Cross Blue Shield of Massachusetts is an HMO and PPO plan with a Medicare contract.
Enrollment in Blue Cross Blue Shield of Massachusetts depends on contract renewal.
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.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-800-200-4255** (TTY: **711**).
ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para **1-800-200-4255** (TTY: **711**).