SUBSCRIBER CLAIM FORM

P.O. Box 64338
St. Paul, Minnesota 55164-0338

DO NOT COMPLETE SHADED AREAS

1-2

01 COPY FROM BLUE CROSS AND BLUE SHIELD OF MINNESOTA ID CARD

IDENTIFICATION NUMBER (15–27)	GROUP NUMBER (28–34)

SUBSCRIBER'S LAST NAME (25–52)	FIRST NAME (53–64)	INIT. (65)	66

02

PATIENT'S LAST NAME (15–32)	FIRST NAME (33–44)	INIT. (45)	PATIENT'S BIRTHDATE MO. DAY YR. (46–51)

PATIENT'S SEX: ☐ (1) MALE ☐ (2) FEMALE 52

PATIENT'S RELATIONSHIP TO SUBSCRIBER: ☐ (1) SELF ☐ (2) SPOUSE ☐ (3) DEPENDENT (Not Spouse) 53

54 IS CONDITION JOB RELATED? ☐ (1) YES ☐ (2) NO ☐ (3) W

03

SUBSCRIBER'S ADDRESS, STREET (15–40)	CITY (41–61)	STATE (62–63)	ZIP CODE (64–68)

04 IS THIS SERVICE RELATED TO: ☐ (1) ILLNESS ☐ (2) INJURY ☐ (3) MATERNITY ☐ (4) AUTO ACCIDENT 15

MO. DAY YR. 21

IF ILLNESS, DATE OF FIRST SYMPTOM
IF INJURY, DATE OF ACCIDENT IS REQUIRED
IF MATERNITY, DATE OF LAST MENSTRUAL PERIOD

IF HOSPITALIZED:	ADMISSION DATE MO. DAY YR. (33–38)	DISCHARGE DATE MO. DAY YR. (39–44)	NAME OF FACILITY	NAME OF ADMITTING PHYSICIAN

SYMPTOMS AND/OR DIAGNOSIS

Name of doctor or other health care professional providing service____________________

Address____________________

OTHER COVERAGE?

Does patient have other insurance coverage ☐ No ☐ Yes If Yes, indicate identification number and name and address of other insurance carrier.

__________ IDENTIFICATION NUMBER __________ NAME __________ ADDRESS

Was this service related to an automobile accident or work-related accident? ☐ Yes ☐ No If yes, please provide the name and address of the auto insurance or workers' compensation carrier.

__________ NAME __________ ADDRESS

MEDICARE? Medicare HIC #____________________

Is patient eligible for Part A Medicare Hospital Insurance? ☐ Yes ☐ No.

Is patient eligible for Part B Medicare Hospital Insurance? ☐ Yes ☐ No If Yes, you must also include a copy of your Explanation of Medicare Benefits form with the itemized bill.

The information given above is true and correct to the best of my knowledge. **A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.**

Signature ____________________ Date Signed __________

Telephone Number Home: ____________________ Office: __________

IMPORTANT, PLEASE READ THE FOLLOWING: Claims must be submitted within the timeframe specified by your contract.

HOW TO SUBMIT YOUR CLAIM:

1. Complete a separate Subscriber Claim Form for each patient and for each doctor or other medical provider. Please answer all questions to get the fastest claims service.
2. Attach a copy of the **itemized bill** from the doctor's office. The bill should show:
   – the doctor's name and address
   – the diagnosis or symptoms of illness
   – the date, place and type of service
   – the charge for each service
3. **For Medicare patients only:** In addition to your itemized bill, attach a copy of your Explanation of Medicare Benefits form.

NOTE: We cannot return your claim or materials you send with it. Please make copies for your personal files.