BlueCross BlueShield of Mississippi

SUBSCRIBER MEDICAL CLAIM FORM

• • • IMPORTANT: PLEASE READ THE INSTRUCTIONS ON THE BACK OF THIS FORM • • •

• • Your Physician does not need to sign this form • •

Please complete and sign a separate form for each patient

PATIENT INFORMATION

1. Patient's Name (No nicknames please)
   First MI Last

2. Subscriber Name as Shown on I.D. Card
   First MI Last

3. Patient's Date of Birth
   ____ / ____ / ____
   Month Day Year

4. Subscriber Identification Number as Shown on I.D. Card

5. Group Number

6. Type Contract

7. Patient's Sex
   ☐ Male ☐ Female

8. Patient's Relationship to Subscriber
   ☐ Self ☐ Child ☐ Spouse ☐ Other

9. Current Mailing Address
   Street City State Zip

   Current Telephone Numbers: Home ____ Area Code Office (optional) ____ Area Code

   Payments and Explanation of Benefits will be sent to the most current address listed in our files. If your address changes, you must contact our Membership Services Department.

OTHER HEALTH INSURANCE INFORMATION

10. Is patient covered under any other health insurance plan? ☐ Yes ☐ No

    If yes, complete the following: Name of Policyholder ____
    Last First Middle

    Name of Employer (if group coverage) ____

    Name and Address of Insuring Company ____
    Name

    ____
    Street

    Policy # ____ ____
    City State Zip

11. Is patient covered under Medicare Part A (hospital) or Medicare Part B (medical):

    Medicare Part A ☐ Yes ☐ No Effective Date ____ / ____ / ____
    Month Day Year

    Medicare Part B ☐ Yes ☐ No Effective Date ____ / ____ / ____
    Month Day Year

    Medicare Identification # ____

    Is subscriber still actively employed?
    ☐ Yes ☐ No

    If no, please enter effective date of retirement.
    ____ / ____ / ____
    Month Day Year

CONDITION AND TREATMENT

12. Was condition related to:
    Employment ☐ Auto Accident ☐ Other Accident/Injury ☐ Illness ☐

13. If Accident/Injury, give date.
    ____ / ____ / ____
    Month Day Year

14. Describe the nature of accident or illness and list symptoms.

AUTHORIZATION

I certify that the information I have given is accurate to the best of my knowledge and that I, as the Subscriber, am claiming benefits only for the charges incurred by the patient identified above. I authorize the release of any medical information necessary to process this claim.

Subscriber's Signature ____ Date ____

WHEN SHOULD YOU USE THIS FORM?

This form is designed to help you, our Subscriber, file itemized medical bills for you or an enrolled family member. You should not submit this form if your Health Care Provider has filed a claim for you. Retain your receipt for your records.

If your benefit program includes the Key Physician Network and services are rendered by a Key Physician or other Participating Provider, these providers will file claims for you. **Please do not file claims for the services of a Key Physician or a Participating Provider – even if you have paid the services in full, and even if the Key Physician or Participating Provider gave you a receipt.** (Refer to your Provider Network Directory for a list of Participating Providers when you need health care services.)

PLEASE REVIEW YOUR MEDICAL BILLS AND FILE CLAIMS AT LEAST ONCE A MONTH TO ENSURE THE TIMELY PROCESSING OF YOUR CLAIMS.

CLAIMS FILING INSTRUCTIONS

1 Gather All Your **Itemized Medical Bills**

2 Separate Your Bills For Each Family Member

3 Complete a Separate Claim Form For Each Family Member

- Attach **Itemized Medical Bills** for the patient named on the form. Each itemized bill must include the patient's name; the health care provider's name and address; the date of each service; descriptions and charge for each service.
- If you are covered under any other health insurance or under Medicare Part B (medical), you must attach a copy of the Explanation of Benefits indicating their payment.
- Please use the Subscriber Prescription Drug Form to file any prescription drugs.

DID YOU

**** USE A SEPARATE CLAIM FORM FOR EACH FAMILY MEMBER?

**** COMPLETE EACH SECTION OF THE CLAIM FORM ENTIRELY?

**** COPY YOUR IDENTIFICATION NUMBER DIRECTLY FROM YOUR ID CARD?

**** ATTACH THE ORIGINAL ITEMIZED BILL(S) FROM THE PROVIDER THAT DESCRIBES ALL SERVICES RENDERED AND INCLUDES DATES OF SERVICE AND CHARGES?

**** KEEP A COPY FOR YOUR RECORDS?

Please forward your completed form to:

Blue Cross & Blue Shield of Mississippi, Inc.
P. O. Box 1043
Jackson, Mississippi 39215-1043

For further information or additional copies of this form, please contact our Customer Service Department. (601) 932-3704

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