SUBSCRIBER CLAIM FORM

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

COPY FROM BLUE CROSS AND BLUE SHIELD OF MINNESOTA ID CARD

DO NOT COMPLETE SHADED AREAS

1-2

01

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	PATIENT'S RELATIONSHIP TO SUBSCRIBER	IS CONDITION JOB RELATED?
(1) MALE (2) FEMALE 52	(1) SELF (2) SPOUSE (3) DEPENDENT (Not Spouse) 53	54 (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:	MO. DAY YR.	
(1) ILLNESS (2) INJURY (3) MATERNITY (4) AUTO ACCIDENT 15	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 15 months of the date of service.

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.