Blue Cross Blue Shield of Michigan

is a nonprofit corporation and independent licensee of the Blue Cross Blue Shield Association

MASTER MEDICAL CLAIM FORM

Reset

PLEASE FILL OUT ON LINE, PRINT OUT, SIGN, AND MAIL TO ADDRESS BELOW

INSTRUCTION FOR FILING A CLAIM

- For each eligible family member, dependent or spouse separate all itemized bill(s), receipts(s), copies of Explanation of Benefits forms or check vouchers.
- Boxes 1 through 15 must be completed.
- If you answer "YES" to box number 14, please complete boxes 16 through 24.
- Complete a separate claim form for each eligible member. Note: Only one claim form per member is needed regardless of the number of receipts.
- Staple or paperclip each member's itemized bill(s) or receipt(s) to his/her completed claim form(s).
- All receipts submitted must include the provider signature and provider code.
- If applicable, attach copies of your Explanation of Medicare Benefits form or Medicare Benefit form or Medicare Voucher.
- Please do not peel and stick receipts to the claim form
- Save copies of all items submitted.
- Claim forms must be signed by the subscriber (contract holder, box number 15).
- Cash register receipts, cancelled checks, money order receipts, unsigned receipts or statements and personal itemizations are not acceptable and if submitted become the property of BCBSM.

NOTE: For best service, please submit your Master Medical claims to us as service occur.

SUBSCRIBER INFORMATION

1. SUBSCRIBER'S LAST NAME	2. SUBSCRIBER'S FIRST NAME				
3. STREET ADDRESS ☐ Check here if new address		CITY			
STATE	ZIP CODE	4. CONTRACT NUMBER TAKEN FROM YOUR BCBSM I. D. CARD ›	SUBSCRIBER'S CONTRACT NUMBER	5. THIS INFORMATION CAN BE TAKEN FROM YOUR BCBSM I. D. CARD ›	BCBSM GROUP NUMBER

PATIENT INFORMATION

6. PATIENT'S LAST NAME	7. PATIENT'S FIRST NAME				PATIENT'S DATE OF BIRTH
9. PATIENTS RELATIONSHIP TO SUBSCRIBER ☐ SELF ☐ SPOUSE ☐ DEPENDENT	10. PATIENT SEX ☐ M ☐ F	11. ACCIDENT: ☐ YES ☐ NO	12. IF YES GIVE DATE OF ACCIDENT ›	DATE OF ACCIDENT	**FOR BCBSM USE ONLY**
13. WORKER's COMPENSATION? ☐ YES ☐ NO	14. OTHER HEALTH CARE COVERAGE ☐ YES ☐ NO	**IF YES, COMPLETE BOXES 16 THROUGH 24**			

OTHER CARRIER INFORMATION

16. OTHER POLICY HOLDER'S LAST NAME	17. OTHER POLICY HOLDER'S FIRST NAME		18. OTHER POLICY HOLDER'S SOCIAL SECURITY NUMBER
19. OTHER POLICY HOLDER'S DATE OF BIRTH	20. NAME OF OTHER HEALTH CARRIER		
21. OTHER CARRIER POLICY/GROUP NUMBER	22. OTHER CARRIER STREET ADDRESS		
CITY	STATE	ZIP CODE	23. OTHER EMPLOYER NAME

24. TYPE OF OTHER HEALTH INSURANCE:
☐ MAJOR MEDICAL ☐ DENTAL ☐ VISION ☐ PRESCRIPTION DRUGS ☐ HOSPITAL/PHYSICIAN ☐ OTHER

CERTIFICATION STATEMENT

I certify that the above information is true and the attached material is correct and unaltered and that the expenses were incurred by the above named patient. I understand all material submitted becomes the property of Blue Cross Blue Shield of Michigan and may not be returned. I realize false receipts or fraudulent alterations of these materials will result in civic or criminal prosecution. I authorize the release of any information necessary to process or review this claim.

SUBSCRIBER'S SIGNATURE (REQUIRED) _____ DATE _____ ( ) PHONE NUMBER

YOUR RIGHT TO CONFIDENTIALITY

We will not release any information about you except: 1) When you ask us to in writing, or 2) when release (to another insurance company for example) is necessary to process or review a claim. We will tell you which information we released to whom, if you request it.

NOTE: FOR REIMBURSEMENT OF MASTER MEDICAL CLAIMS ONLY, MAIL TO:

MASTER MEDICAL DEPT., M.C. B550
BLUE CROSS BLUE SHIELD OF MICHIGAN
P.O. BOX 172
DETROIT, MI 48231-0172

CLAIM NUMBER (FOR BCBSM USE ONLY)										