

MASTER MEDICAL CLAIM FORM

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	
13. WORKER'S COMPENSATION? ☐ YES ☐ NO		14. OTHER HEALTH CARE COVERAGE ☐ YES ☐ NO		DATE OF ACCIDENT	
IF YES, COMPLETE BOXES 16 THROUGH 24					

FOR BCBSM USE ONLY

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:

**SPECIAL CLAIMS PROCESSING, M. C. B532
BLUE CROSS BLUE SHIELD OF MICHIGAN
P.O. BOX 172
DETROIT, MI 48231-0172**

CLAIM NUMBER (FOR BCBSM USE ONLY)