Excellus

A nonprofit independent licensee of the BlueCross BlueShield Association

PLEASE REVIEW AND LEGIBLY COMPLETE ALL SECTIONS (1-5) OF THIS FORM

Please Note-*If you do not have all of the required information, please contact the provider of service for assistance prior to submitting your claim. Failure to supply all of the required information may result in delayed processing and/or subsequent return or denial of your claim submission*

If your address has changed or is incorrect, please call our Customer Service Department at the telephone numbers listed on your identification card.

MEDICAL BENEFITS

SUBSCRIBER CLAIM FORM

Mail completed form and all required information to:

Excellus BlueCross BlueShield
P.O. Box 22999
Rochester, NY 14692

SECTION 1
INFORMATION REQUIRED FROM SUBSCRIBER

1a-HAVE SUBMITTED EXPENSES BEEN PAID IN FULL BY YOU? ☐ YES ☐ NO

Please Note-If a participating provider rendered the service(s) being submitted, payment will be made directly to the provider.

1b-ITEMIZED BILL(S) FOR SERVICES OR SUPPLIES **MUST BE SUBMITTED** WITH THIS FORM IN ORDER FOR REIMBURSEMENT TO BE CONSIDERED. THE ITEMIZED BILL MUST ***CLEARLY*** INDICATE **ALL OF THE FOLLOWING**:

1-PATIENT'S FULL NAME AND DATE OF BIRTH

2-NAME AND ADDRESS OF THE PROVIDER OF SERVICE ON THEIR OFFICE LETTERHEAD, INCLUDING PROVIDER ID NUMBER AND CREDENTIALS

3-DATE FOR **EACH** SERVICE RENDERED

4-DESCRIPTION AND/OR VALID PROCEDURE CODE FOR **EACH** SERVICE RENDERED

5-CHARGE FOR **EACH** SERVICE RENDERED

6-DESCRIPTION OF ILLNESS/INJURY AND/OR VALID DIAGNOSIS CODE FOR **EACH** SERVICE RENDERED

7-COUNTRY MUST BE INDICATED AND **ALL** INFORMATION TRANSLATED TO ENGLISH FOR ANY SERVICE(S) NOT RENDERED IN THE USA

8-PRESCRIPTION NUMBER AND NAME OF PRESCRIBING PHYSICIAN MUST BE INDICATED ON RX/MEDICINE BILLS

SECTION 2
SUBSCRIBER /PATIENT INFORMATION

Please enter all information exactly as shown on your ID card

2a-SUBSCRIBER'S LAST NAME	2b-FIRST NAME	2c-INITIAL	2d-SUBSCRIBER IDENTIFICATION NUMBER (Including Prefix)

2e-ADDRESS-NUMBER AND STREET	2f-CITY	2g-STATE	2h-ZIP CODE

2i-PATIENT'S LAST NAME	2j-FIRST NAME	2k-INITIAL	2L-DATE OF BIRTH	2m-GENDER	2n-PATIENT'S RELATIONSHIP TO SUBSCRIBER
			___/___/___ mm dd yyyy	☐ M ☐ F	☐ SELF ☐ CHILD ☐ SPOUSE

SECTION 3
OTHER HEALTH INSURANCE INFORMATION

3a-IS THE PATIENT COVERED BY ANOTHER HEALTH INSURANCE PLAN (INCLUDING MEDICARE)? ☐ YES ☐ NO

If YES, please complete 3b-3g below

3b-NAME OF OTHER POLICYHOLDER	3c-POLICY OR IDENTIFICATION NUMBER

3d-POLICY EFFECTIVE DATE:	3e-TYPE OF POLICY/COVERAGE:	3f-POLICYHOLDER'S DATE OF BIRTH:
___/___/___ mm dd yyyy	☐ INDIVIDUAL ☐ TWO-PERSON ☐ FAMILY	___/___/___ mm dd yyyy

3g-NAME AND ADDRESS OF OTHER INSURANCE CARRIER

Please Note-*If the patient has other primary insurance, the Explanation of Benefits form(s) from the other health insurance plan must accompany this claim form, along with the matching itemized bill.*

SECTION 4
MOTOR VEHICLE/WORK-RELATED INFORMATION

4a-ARE THE SUBMITTED EXPENSES RELATED, IN ANY WAY, TO A MOTOR VEHICLE OR WORK-RELATED ACCIDENT OR INJURY?

☐ YES ☐ NO

If YES, *please complete 4b & 4c below*

4b-TYPE OF ACCIDENT: ☐ WORK ☐ MOTOR VEHICLE ☐ OTHER	4c-DATE OF ACCIDENT OR INJURY: ___/___/___ mm dd yyyy

SECTION 5
SIGNATURE AND DATE

I CERTIFY THAT THE INFORMATION SUBMITTED IS ACCURATE TO THE BEST OF MY KNOWLEDGE. I AUTHORIZE THE RELEASE OF ANY RELEVANT INFORMATION TO MY INSURANCE CARRIER.

SUBSCRIBER SIGNATURE: _____ **DATE:** _____

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information, or conceals information concerning any fact material thereto, for the purpose of misleading, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed $5,000 and the stated value of each violation.