



SUBSCRIBER SUBMITTED



YOU MAY NOT NEED TO FILE THIS CLAIM FORM. ASK THE PROVIDER OR HOSPITAL TO BILL THEIR LOCAL BLUE CROSS AND BLUE SHIELD PLAN DIRECTLY. MEDICARE: YOU MAY NOT NEED TO FILE THIS CLAIM FORM. ASK THE PROVIDER OR HOSPITAL IF THEY HAVE BILLED MEDICARE OR BLUE CROSS AND BLUE SHIELD DIRECTLY OR IF THE PROVIDER ACCEPTED MEDICARE ASSIGNMENT FOR THESE SERVICES.

INSTRUCTIONS (Please turn over for examples)
1. Please print or type a separate form for each patient.
2. Attach to each form an itemized statement, bill or receipt which includes: provider's name and address, primary enrollee's contract number, full name of patient, date and description of each service, diagnosis/nature of illness, and amount charged.
3. Save copies of all items you submit. All materials submitted will be kept for our files.
4. Send to the appropriate address shown on the back of this form.

Form fields for subscriber and patient information: 1. SUBSCRIBER LAST NAME, 2. FIRST NAME, 3. STREET ADDRESS, CITY, STATE, ZIP CODE, PREFIX, 4. CONTRACT NUMBER, 5. GROUP NUMBER, 6. PATIENT LAST NAME, FIRST NAME, DATE OF BIRTH, MO, DAY, YEAR, 7. IS PATIENT ENROLLED WITH MEDICARE?, 8. MEDICARE H.I.B. NUMBER, 9. IS PATIENT COVERED BY OTHER HEALTH INSURANCE?, BCBS USE ONLY, 10. NAME OF OTHER INSURANCE CARRIER, 11. CITY, STATE, ZIP CODE, 12. NAME OF POLICY HOLDER, 12a. POLICY NUMBER, 13. POLICY HOLDER'S DATE OF BIRTH

(If you received partial payment from another company, please attach a copy of their check voucher or Explanation of Benefits form.)

Form fields for accident and hospitalization details: 14. Relationship to Primary Enrollee, 15. Sex, 16. Were Injuries or Illness related to patient's employment?, 17. Were Injuries the result of an auto accident?, 18. Date of accident, 19. If patient was hospitalized, give dates below.

Form fields for provider information: 20. PROVIDER'S NAME, 21. STREET ADDRESS, 22. CITY, STATE, ZIP CODE, TAX I.D. (FOR PROVIDER USE ONLY)

CERTIFICATION STATEMENT
I certify that the above information is true, 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 and Blue shield and may not be returned.

CLAIM NUMBER (FOR BCBSM USE ONLY), SUBSCRIBER'S SIGNATURE, DATE, TELEPHONE NUMBER

SUBSCRIBER'S CLAIM FORM INSTRUCTIONS

PLEASE READ AND FOLLOW INSTRUCTIONS LISTED BELOW

HOW TO FILE CLAIMS: IF YOUR PHYSICIAN DOES NOT ELECT TO BILL DIRECTLY AND GIVES YOU AN ITEMIZED BILLING, COMPLETE THE TOP PORTION ONLY. COMPLETE A SEPARATE CLAIM FORM FOR EACH ELIGIBLE FAMILY MEMBER.

- ITEMS 1 & 2-COMplete ITEMS 1 & 2 EXACTLY AS THEY APPEAR ON YOUR BLUE CROSS AND BLUE SHIELD I.D. CARD.
- ITEM 3-ENTER YOUR STREET ADDRESS, CITY, STATE AND ZIP CODE.
- ITEMS 4 & 5-COMplete EXACTLY AS IT APPEARS ON YOUR BLUE CROSS AND BLUE SHIELD I.D. CARD.
- ITEM 6-ENTER THE PATIENT'S NAME AND DATE OF BIRTH.
- ITEM 7-YOU MUST CHECK EITHER "YES" OR "NO".
- ITEM 8-IF YOUR PROVIDER DID NOT ACCEPT MEDICARE ASSIGNMENT, ENTER THE COMPLETE MEDICARE IDENTIFICATION NUMBER AND LETTER. IF YOU HAVE ALREADY RECEIVED THE MEDICARE PAYMENT AND ARE REQUESTING COMPLEMENTARY COVERAGE PAYMENT ONLY, BE SURE TO ATTACH THE EXPLANATION OF MEDICARE BENEFITS (E.O.M.B.) THAT WAS SENT TO THE PATIENT, EXPLAINING CHARGES PAID OR DENIED BY MEDICARE.
- ITEMS 9-13-YOU MUST CHECK EITHER "YES" OR "NO" FOR ITEM 9. IF YOU CHECK "YES" COMPLETE 10-13. GIVE CARRIER NAME, POLICY NUMBER, POLICY HOLDER'S NAME AND INSURANCE CO. ADDRESS. IF YOU RECEIVED PARTIAL PAYMENT FROM ANOTHER INSURANCE CARRIER, YOU MUST ATTACH A COPY OF THE CHECK VOUCHER OR EXPLANATION OF BENEFITS FORM THAT WAS SUPPLIED BY THE CARRIER.
- ITEM 14-RELATIONSHIP TO THE SUBSCRIBER.
- ITEM 15-ENTER THE PATIENT'S SEX.
- ITEM 16-IF THE ILLNESS OR INJURY WAS CONNECTED WITH THE PATIENT'S EMPLOYMENT, CHECK "YES". IF NOT, CHECK "NO".
- ITEM 17-CHECK "YES" IF THE INJURIES WERE THE RESULT OF AN AUTO ACCIDENT, IF NOT, CHECK "NO".
- ITEM 18-IF ITEM 17 ABOVE WAS CHECKED "YES", PLEASE GIVE DATE OF AUTO ACCIDENT.
- ITEM 19-IF ANY OF THE BILLS ARE FOR HOSPITAL EXPENSES, ENTER THE ADMISSION AND DISCHARGE DATES.
- ITEMS 20-22-ENTER THE NAME AND ADDRESS OF THE PHYSICIAN WHO PERFORMED THE SERVICES YOU ARE REPORTING. IF YOU ARE ATTACHING RECEIPTS FROM MORE THAN ONE PHYSICIAN, DO NOT COMPLETE THIS PORTION.

MAKE ANY NEEDED COPIES OF THE CLAIM FORM AND RECEIPTS FOR YOUR USE BEFORE MAILING THE ORIGINALS. DO NOT MAIL XEROX COPIES. MATERIALS SUBMITTED WILL BE RETAINED FOR OUR FILES.

EXAMPLES OF PROPERLY ITEMIZED RECEIPTS

PHARMACY RECEIPT

<ol style="list-style-type: none"> 1. Name and Address of Provider 2. Full Name of Patient 3. Date of Purchase (Mo./Day/Yr.) 4. Prescription Number 5. Drug Name 6. Separate Charge for each Prescription 	<table style="width: 100%; border-collapse: collapse;"> <tr> <td colspan="4" style="text-align: center;">PRICE PHARMACY</td> </tr> <tr> <td colspan="4" style="text-align: center;">200 Market Street Hometown</td> </tr> <tr> <td colspan="4" style="text-align: center;">PATIENT'S FULL NAME JOHN DOE</td> </tr> <tr> <td style="text-align: center;">DATE</td> <td style="text-align: center;">PRESCRIPTION NO.</td> <td style="text-align: center;">DRUG NAME</td> <td style="text-align: center;">CHARGE</td> </tr> <tr> <td style="text-align: center;">12/29/98</td> <td style="text-align: center;">#12469</td> <td style="text-align: center;">TYLENOL #3</td> <td style="text-align: center;">\$ 4.15</td> </tr> <tr> <td></td> <td style="text-align: center;">#12470</td> <td style="text-align: center;">PENICILLIN</td> <td style="text-align: center;">\$19.95</td> </tr> <tr> <td colspan="3"></td> <td style="text-align: center;">\$24.10</td> </tr> </table>	PRICE PHARMACY				200 Market Street Hometown				PATIENT'S FULL NAME JOHN DOE				DATE	PRESCRIPTION NO.	DRUG NAME	CHARGE	12/29/98	#12469	TYLENOL #3	\$ 4.15		#12470	PENICILLIN	\$19.95				\$24.10
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PHYSICIAN RECEIPT

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MAIL TO:

**Blue Cross and Blue Shield of Michigan
NASCO Claims Processing Center — National Groups
P.O. Box 5124
Southfield, Michigan 48086-5124**