MEMBER CLAIM FORM

Do not file prescription drugs on this form. Type or use blue or black ink to complete.

- Visit **bcbsnc.com** for prescription drug, dental and international claim forms, or call the toll-free number on your ID card. Filing Requirements:
 - o Complete a separate claim form for each covered family member.
 - Enclose itemized receipts and make copies for your records. See Section IV for required information.
 - o Do not file a claim if the provider is filing for the same services.
 - Attach Explanation of Benefits if these services are covered by another insurance policy.
 - o Claims must be filed within 18 months from the date services were received, or they will be denied.
 - Please see Section VI for mailing information.

Any claim filed without the required documentation listed above will be returned.

SECTION I: Patient Information Please enter the subscriber number from your ID card.								
Subscriber Begin with Number: letter prefix		2 digits preceding patient's name (see ID card)						
Patient's Last Name:	First Name:	Middle Initial:						
	☐ Male Relationship	Self Child						
of Birth:	Female to Subscriber:	Spouse Other:						
SECTION II: Mailing Information Please check here if address has changed.								
Subscriber Name:								
Substitute Name.	THE PERSON OF TH							
Address (Line 1):								
Address (Line 2):								
City:	State: NC ZIP Code:							
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SECTION III: Other Insurance Information								
Please complete the information below if the patient is covered by another health insurance policy.								
Does the patient								
Other policy number:	Other policy							
number: holder's name: Other policy holder's employer name:								
Please complete the information below if the patient is covered by Medicare:								
Medicare health insurance claim number: Spatient Part A Part eligible for: Part B								

PLEASE NOTE: If your other insurance or Medicare policy is primary, you must attach a copy of the Explanation of Benefits from that insurer. Your claim cannot be processed without this information.

An independent licensee of the Blue Cross and Blue Shield Association. ®,SM Marks of the Blue Cross and Blue Shield Association. SM1 Mark of Blue Cross and Blue Shield of North Carolina. BE236, 12/07



These may include BCBSNC requir	ervices and Supplies To Be Conside ambulance services, medical appliances, es that procedure codes and diagn ims or itemized receipts received w	, diabetic supplies, gl iosis codes on the	asses and/or contact lenses itemized receipt be sup	plied by the	
Please indicate v	where services were rendered if not i	in North Carolina: _			
Country:			Currency Used:		
Date of Service (MM-DD-YY)	Procedure Codes or Description of Service/Supplies		Diagnosis Codes or Symptoms You Sought Treatment For		Charge
01-05-07	Office Visit	V 2007-AV	Cold and Flu Symptoms		54.00
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ECTION V: Pri	ivate Duty Nursing Enclose a cop	y of your receipts fo	or these services.	West the second	
Date of Service (MM-DD-YY)	Name of Nurse	Indicate RN, LPN or CNA	1!	Hours Worked	Charge
03-10-07	EXAMPLE: Ms. Jane M. Doe	LPN	123456	8	160.00
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MAIL THIS EXPLANAT Blu	FORM, ITEMIZED RECEIPTS AND TON OF BENEFITS (if applicable) To a Cross and Blue Shield of North Car	O:	DID YOU REMEMBER TO Use blue or black ink to Attach the Explanation Attach itemized receipt	complete the of Benefits, if a	
	D. Box 35 ham, NC 27702		 Provide your signature Keep a copy of this form 	below?	eipts?

I certify that the information on this form is correct and the expenses incurred were necessary for the services filed.						
		Daytime Phone				
Signature:	Date:	Number:				