

# Subscriber Claim Form

## Page 1

Return to:  
Blue Cross of Washington  
and Alaska  
P.O. Box 91080  
Seattle, WA 98111-9180



**Blue Cross**  
of Washington and Alaska  
An Independent Licensee of the  
Blue Cross and Blue Shield Association

Check this box if you need more Subscriber Claim Forms.

**Please use a separate claim form for each patient** and each provider of service (such as doctor or laboratory).

**This form must be filled out completely.**

Leaving any questions unanswered on this form may cause your claim to be returned and processing to be delayed until the information is completed.

When you've answered all the questions below, turn the form over and complete the section of page 2 that applies to your claim.

**Do not use this form for prescription reimbursement.** Please use the *PAID Prescriptions* Claim Form. (Call the Customer Service number listed on the back of your ID card for the proper form.)

**Do not use this form if the services were obtained outside of Washington or Alaska. Ask your provider to submit a regular claim form to their local Blue Cross/Blue Shield plan to be processed through The BlueCard program. Foreign country claims can be filed on this Subscriber Claim Form.**

### WHO IS THE PATIENT?

Name (First—Middle—Last)		What is the patient's relationship to the subscriber? <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other _____	
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Birthdate (Month/Day/Year) / /	Is the patient: A full-time student? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No Physically or developmentally disabled? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No	
If the patient is a dependent child of divorced parents, who has legal custody? <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> _____ Who has financial responsibility? _____		If the patient received the care outside the United States of America, what is the name of the country? _____	

### WHO IS THE SUBSCRIBER? (PERSON NAMED ON BLUE CROSS CARD)

Name (First—Middle—Last)	Identification Number <b>Z</b> <b>K</b> <b>A</b> [ ] [ ] [ ] - [ ] [ ] - [ ] [ ] [ ] [ ]		
Employer	Group Number	Subscriber is <input type="checkbox"/> Actively employed <input type="checkbox"/> Retired	
Present Home Address (Street number and address or rural route, city, town or post office, state and ZIP code) [ ] Check here if this is a new address		Telephone Numbers Daytime ( ) Evening ( )	

### PLEASE ANSWER THE FOLLOWING QUESTIONS.

- Payment information: Have these charges been paid in full?  Yes  No
- Does the patient have other medical (other than Medicare), dental or vision coverage?  Yes  No If "Yes," what is the:  

Subscriber's name	Identification Number	Birthdate
	(usually the social security number)	Month/Day/Year
Employer's Name	Address	Phone No.
		Group No.
Other Insurance Co. Name	Address	Phone No.
- Other insurance covers:  Medical  Dental  Vision
- If covered by Medicare, check the type of Medicare coverage the patient has  Part A (Hospital)  Part B (Medical)  
 On what date did this Medicare coverage go into effect? .....(Month/Day/Year). Part A / / Part B / /  
 What is the Medicare identification number? [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]
- Did the condition result from an accident?  Yes  No If "Yes," complete ACCIDENT INFORMATION on PAGE 2.
- Have you been treated for this condition before?  Yes  No If "Yes," list dates treated / /  
Month/Day/Year
- What was the exact date the condition started? (Month/Day/Year) / /
- Is this expense pregnancy related?  Yes  No If "Yes," what was the date of conception? / /  
Month/Day/Year
- In what setting were these services performed?  
 Inpatient hospital  Outpatient hospital  Office/Clinic  Surgery Center  Skilled Nursing Facility  Home  
 Other \_\_\_\_\_

**PLEASE TURN OVER**

# Subscriber Claim Form

## Page 2

Complete a separate claim form for each provider of service, such as doctor or laboratory.

An **itemized bill** is a form the provider uses that details the services provided and the cost of each service. It is not a statement which shows only the balance due.

Please do not use for more than one provider or patient.

**FOR DENTAL CLAIM (ITEMIZED BILL MUST BE ATTACHED)**

Was the treatment for orthodontic care?  Yes  No

Did treatment include an artificial device(s) such as dentures, bridge(s), crown(s), etc.?  Yes  No

If "Yes," was the treatment to replace an existing artificial device? \_\_\_\_\_

If "Yes," please explain why the replacement was necessary and give the date (if known) of the last replacement. \_\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Month/Day/Year

**FOR VISION CLAIM (ITEMIZED BILL MUST BE ATTACHED)**

If lenses were prescribed, what type?  Single  Bifocal  Trifocal  Contact  Other (please specify) \_\_\_\_\_

**FOR ALL OTHER CLAIMS — DOCTOR, CLINIC, LAB, ETC. (ITEMIZED BILL MUST BE ATTACHED)**

What was the condition requiring treatment? (Diagnosis)  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Check here if routine physical examination

Is the condition work related?  Yes  No

Has the patient or will the patient file a workers' compensation claim?  Yes  No

Is this a second surgical opinion?  Yes  No

Is this a third surgical opinion?  Yes  No

Surgical procedure \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**ACCIDENT INFORMATION**

.....

Where did the accident occur?

At work  At home  Auto  Other \_\_\_\_\_

What was the exact date of the accident/injury? \_\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
(Month/Day/Year)

If auto accident, do you have:

Personal injury protection?  Yes  No

Uninsured or underinsured coverage?  Yes  No

Medical payment coverage?  Yes  No

Name and address of auto insurance company:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you intend to make a claim against a third party?  Yes  No

A person who knowingly and with intent to injure, defraud or deceive an insurance company files a claim containing false, incomplete, or misleading information **may be prosecuted under state law.**

**X**

Subscriber's signature

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date Month/Day/Year

**To be accepted, this form must be fully completed, signed, and have proper bills attached.**