P.O. Box 240609
Anchorage, AK 99524-0609

PREMERA | BLUE CROSS BLUE SHIELD OF ALASKA

MEMBER CLAIM FORM

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

All information that is applicable to the claim being submitted must be completed. Leaving any applicable questions unanswered 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 *Prescription Drug Reimbursement Form* for primary prescription claim submission and the *Secondary Insurance Prescription Drug Claim Form* for secondary prescription claim submission. (Call the Customer Service number listed on the back of your ID card for the proper form.)

1. WHO IS THE PATIENT?

Name (First—Middle—Last) ____________________

Gender ☐ Male ☐ Female

Birthdate (Month/Day/Year) / /

If the patient is a dependent child of divorced parents, who has legal custody? ☐ Mother ☐ Father ☐ ____________

Who has financial responsibility under the divorce decree? ____________

What is the patient's relationship to the subscriber?
☐ Self ☐ Spouse ☐ Child ☐ Other ____________

Is the patient:
A full-time student? ☐ No ☐ Yes
Physically or developmentally disabled? ☐ No ☐ Yes

If the patient received the care outside the United States of America, what is the name of the country?
____

2. WHO IS THE SUBSCRIBER? (PERSON IN WHOSE NAME COVERAGE WITH PREMERA BLUE CROSS BLUE SHIELD OF ALASKA IS ESTABLISHED)

Name (First—Middle—Last)

Prefix and Indentification # (Please copy from your ID card)
☐☐☐ ☐☐☐☐☐☐☐☐☐

Employer

Group Number
(please copy from your ID card)

Subscriber is
☐ Actively employed
☐ Retired ☐ Laid off

Mailing Address

☐ Check here if this is a new address

Telephone Numbers
Daytime ( )
Evening ( )

3. PLEASE ANSWER THE FOLLOWING QUESTIONS.

A. Payment information: Have these charges been paid in full? ☐No ☐Yes, please attach proof of payment in full with claim submission.

B. Does the patient have other medical (other than Medicare), dental or vision coverage? ☐No ☐Yes If "Yes," what is the:

Subscriber's Name ____ Identification Number ____ Birthdate / / (Month/Day/Year)

Employer's Name ____ Address ____ Phone No. ____ Group No. ____

Other Insurance Co. Name ____ Address ____ Phone No. ____

Other insurance covers: ☐Medical ☐Dental ☐Vision

C. If covered by Medicare, check the type of Medicare coverage the patient has and enter the date this coverage went into effect.

☐ Part A (Hospital) ____/____/____ ☐ Part B (Medical) ____/____/____ ☐ Part D (Rx) ____/____/____

Reason (check all that apply): ☐ Age ☐ Disability ☐ End Stage Renal Disease Name of Part D Carrier: ____________

What is the Medicare identification number **(must complete)**? ☐☐☐☐☐☐☐☐☐☐

What is the patient's Social Security number **(must complete)**? ☐☐☐-☐☐-☐☐☐☐

D. Did the condition result from an accident? ☐No ☐Yes If "Yes," complete ACCIDENT INFORMATION on PAGE 2.

E. Have you been treated for this condition before? ☐No ☐Yes If "Yes," list dates treated ____/____/____ ____/____/____

F. What was the exact date the condition started? (Month/Day/Year) ____/____/____

G. Is this expense pregnancy-related? ☐No ☐Yes If "Yes," what was the date of conception? ____/____/____

H. In what setting were these services performed?
☐Inpatient Hospital ☐Outpatient Hospital ☐Office/Clinic ☐Surgery Center ☐Skilled Nursing Facility ☐Home
☐Other ____________

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An **itemized bill** is a form the provider uses that details the services received by the member and the cost of each service. It is not a statement which shows only the balance due. Please do not highlight or modify receipts as this may cause delayed processing of your claim.

Complete a separate claim form for each provider of service, such as doctor or laboratory.
Please do not use for more than one provider or patient.

4. FOR DENTAL CLAIM (ITEMIZED BILL MUST BE ATTACHED)

A. Was the treatment for orthodontic care? ☐No ☐Yes

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

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. ______________________________

____

5. FOR VISION CLAIM (ITEMIZED BILL MUST BE ATTACHED)

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

6. 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? ☐No ☐Yes

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

Is this a second surgical opinion? ☐No ☐Yes

Is this a third surgical opinion? ☐No ☐Yes

Surgical procedure ______________________________

____

____

____

____

ACCIDENT INFORMATION

Was the reason for treatment due to an accident? ☐No ☐Yes

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? ☐No ☐Yes

Uninsured or underinsured coverage? ☐No ☐Yes

Medical payment coverage? ☐No ☐Yes

Name and address of auto insurance company:

____

____

____

____

____

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

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 ______________________________ ________ / ________ / ________

Patient's signature (or legal guardian if patient cannot legally consent to services) Date (Month/Day/Year)

To be accepted, this form must be fully completed (as applicable to the claim being submitted), signed, and have proper bills attached.

Mail to: Premera Blue Cross Blue Shield of Alaska
P.O. Box 240609
Anchorage, AK 99524-0609