BlueCross BlueShield of Mississippi

SUBSCRIBER MEDICAL CLAIM FORM

● ● ● IMPORTANT: PLEASE READ THE INSTRUCTIONS ON THE BACK OF THIS FORM. ● ● ●
● ● Your Physician does not need to sign this form. ● ●
Please complete and sign a separate form for each patient.

PATIENT INFORMATION

1. Patient's Name (No nicknames please)
First _____ MI _____ Last _____

4. Subscriber Identification Number as Shown on I.D. Card _____

2. Subscriber Name as Shown on I.D. Card
First _____ MI _____ Last _____

5. Group Number _____

6. Type Contract _____

3. Patient's Date of Birth
_____ / _____ / _____
Month Day Year

7. Patient's Sex
☐ Male ☐ Female

8. Patient's Relationship to Subscriber
☐ Self ☐ Child ☐ Spouse ☐ Other

9. Current Mailing Address

Street _____ City _____ State _____ Zip _____

Current Telephone Numbers: Home _____ (Area Code) Office (optional) _____ (Area Code)

Payments and Explanation of Benefits will be sent to the most current address listed in our files. If your address changes, you must contact our Membership Services Department.

OTHER HEALTH INSURANCE INFORMATION

10. Is patient covered under any other health insurance plan? ☐ Yes ☐ No

If yes, complete the following: Name of Policyholder _____ (Last) _____ (First) _____ (Middle)

Name of Employer (if group coverage) _____

Name and Address of Insuring Company _____ (Name)

_____ (Street)

Policy # _____ _____ (City) _____ (State) _____ (Zip)

11. Is patient covered under Medicare Part A (hospital) or Medicare Part B (medical):

Medicare Part A ☐ Yes ☐ No Effective Date _____ / _____ / _____ (Month Day Year)

Medicare Part B ☐ Yes ☐ No Effective Date _____ / _____ / _____ (Month Day Year)

Medicare Identification # _____

Is subscriber still actively employed?
☐ Yes ☐ No

If no, please enter effective date of retirement.

_____ / _____ / _____ (Month Day Year)

CONDITION AND TREATMENT

12. Was condition related to: Employment ☐ Auto Accident ☐ Other Accident / Injury ☐ Illness ☐

13. If Accident / Injury, give date.
_____ / _____ / _____ (Month Day Year)

14. Describe the nature of accident or illness and list symptoms. _____

AUTHORIZATION

I certify that the information I have given is accurate to the best of my knowledge and that I, as the Subscriber, am claiming benefits only for the charges incurred by the patient identified above. I authorize the release of any medical information necessary to process this claim.

Subscriber's Signature _____ Date _____

WHEN SHOULD YOU USE THIS FORM?

This form is designed to help you, our Subscriber, file itemized medical bills for you or an enrolled family member. You should not submit this form if your Health Care Provider has filed a claim for you. Retain your receipt for your records.

If your benefit program includes the Key Physician Network and services are rendered by a Key Physician or other Participating Provider, these providers will file claims for you. **Please do not file claims for the services of a Key Physician or a Participating Provider – even if you have paid the services in full, and even if the Key Physician or Participating Provider gave you a receipt.** (Refer to your Provider Network Directory for a list of Participating Providers when you need health care services.)

PLEASE REVIEW YOUR MEDICAL BILLS AND FILE CLAIMS AT LEAST ONCE A MONTH TO ENSURE THE TIMELY PROCESSING OF YOUR CLAIMS.

CLAIMS FILING INSTRUCTIONS

1 Gather All Your **Itemized Medical Bills**

2 Separate Your Bills For Each Family Member

3 Complete a Separate Claim Form For Each Family Member

- Attach Itemized Medical Bills for the patient named on the form. Each itemized bill must include the patient's name; the health care provider's name and address; the date of each service; descriptions and charge for each service.
- If you are covered under any other health insurance or under Medicare Part B (medical), you must attach a copy of the Explanation of Benefits indicating their payment.
- Please use the Subscriber Prescription Drug Form to file any prescription drugs.

DID YOU

**** USE A SEPARATE CLAIM FORM FOR EACH FAMILY MEMBER?

**** COMPLETE EACH SECTION OF THE CLAIM FORM ENTIRELY?

**** COPY YOUR IDENTIFICATION NUMBER DIRECTLY FROM YOUR ID CARD?

**** ATTACH THE ORIGINAL ITEMIZED BILL(S) FROM THE PROVIDER THAT DESCRIBES ALL SERVICES RENDERED AND INCLUDES DATES OF SERVICE AND CHARGES?

**** KEEP A COPY FOR YOUR RECORDS?

Please forward your completed form to:

Blue Cross & Blue Shield of Mississippi
P.O. Box 1043
Jackson, Mississippi 39215-1043

For further information or additional copies of this form, please contact our Customer Service Department at (601) 932-3704.

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