Subscriber Claim Form

MASSACHUSETTS

Instructions for Submitting Claims

1. Submit a claim only when you are billed for services from a provider that does not directly submit a claim to the local Blue Cross Blue Shield plan.
2. Submit a separate form for each patient.
3. Attach an **original** itemized bill from your provider **(required information & example on the back)**
4. Keep a copy of all bills and claim forms submitted (originals will not be returned)
5. Be sure to sign and date the completed form.
6. Mail claim form and all attachments to **BCBSMA, P.O. Box 986030, Boston, MA 02298**

Subscriber Information

Identification Number (including alpha prefix)	Last Name	First Name	Middle Initial
Address-Number & Street	City	State	Zip Code
Date of Birth (MM/DD/YY)	Employer's Name		

Patient Information

Patient Last Name	First Name	Middle Initial	Date of Birth (MM/DD/YY)

Gender:

❑ Male

❑ Female

Patient is:

❑ Subscriber (contract holder) ❑ Spouse (to contract holder) ❑ Child (age 18 or younger)

❑ Student (age 19 or older) ❑ Handicapped Dependent (age 19 or older)

❑ Other (specify)_____

Does the patient have other insurance: ❑ Yes ❑ No

Effective Date:

Medicare Part A (Hospital) ❑ Yes ❑ No ___/___/____

Medicare Part B (Medical) ❑ Yes ❑ No ___/___/____

Medicare Part D (Pharmacy) ❑ Yes ❑ No ___/___/____

Other Blue Cross Blue Shield Membership? ❑ Yes ❑ No ___/___/____

Other Insurance Plan? ❑ Yes ❑ No ___/___/____

Identification Number: _____

Name and address of other insurance:

_____

Was treatment for:

Accident at work? ❑ Yes ❑ No

Date of accident ___/___/____

Auto accident? ❑ Yes ❑ No

Date of accident ___/___/____

If yes, name of auto insurance:

_____

Policy Number: _____

Other accident? ❑ Yes ❑ No

Date of accident ___/___/____

Subscriber Signature: Date:

Please allow up to 30 days for your claim to process.

Example of a Complete Itemized Bill

Smith Speech Center
123 Main St.
Boston, MA 12345

To: Joe Smith 15 Elm St. Anytown, MA 12345	Patient Name: Joan Smith Referring Doctor: Dr. John Jones
Jane Johnson, SLP, CCC ← Provider Credentials Speech-Language Pathologist License # Y777777	Tax ID/NPI: 99-9999999

Procedure Code(s)	Units	Procedure Description	Date of Service	Amount
92507	1	Speech–Language Therapy	10/5/2008	$72.50 ← Itemized Charges
92507	2	Speech–Language Therapy	11/3/2008	$145.00
Diagnosis Codes: 784.50, 315.31				**Total:** $290.00
				Payments: $290.00
				Balance Due: $0.00

Please note that your bill does not need to look exactly like the example above, but MUST contain the following required information:

1. A letterhead from the provider that **MUST** include all of the following:
   - Provider name
   - Provider address
   - Provider Tax ID/NPI
   - Provider credentials, i.e., the initials associated with the educational degrees the provider has earned. Examples include: MD, LICSW, DC, PT, OT, ST
2. Patient's name
3. Date(s) of service
4. Itemized charges for each date of service and type of service received
5. Procedure codes (HCPCS/Revenue codes) for all services received
6. Diagnosis code(s) for services received
7. Number of Units-this is the number of times a service was performed on a particular date of service. This is required for occupational, physical & speech therapies, anesthesia and chiropractic services.
8. Attach any related claim summaries or Explanation of Medicare Benefit Forms you may have received for these services, including those received from other insurance companies.
9. When submitting a claim for **PRESCRIPTION DRUGS**, you must submit an itemized receipt from your pharmacy that includes:
   - National Drug Code (NDC)
   - Name of drug
   - Date dispensed
   - Quantity dispensed
   - Name of prescribing physician

To view processed claims, visit our website **http://www.bluecrossma.com/wps/portal/members/.** If you have not already registered for **Member Central**, click **Create an Account** and follow the directions.