DO NOT MARK IN THIS AREA

BlueCross BlueShield of Vermont

An Independent Licensee of the Blue Cross and Blue Shield Association.

SUBSCRIBER CLAIM FORM

Please complete all unshaded areas of this form and attach an itemized statement for all services being submitted. Please see the back of this form for additional important information.

PATIENT AND SUBSCRIBER INFORMATION

1. PATIENT'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL)

2. PATIENT'S DATE OF BIRTH

3. SUBSCRIBER'S NAME (LAST NAME, FIRST NAME, MI)

4. PATIENT'S ADDRESS (STREET, CITY, STATE, ZIP CODE)

TELEPHONE NO.

5. PATIENT'S SEX

MALE ☐ ☐ FEMALE

6. SUBSCRIBER'S I.D. NO.

VT

7. PATIENT'S RELATIONSHIP TO SUBSCRIBER

SELF ☐ SPOUSE ☐ CHILD ☐ OTHER ☐

8. SUBSCRIBER'S GROUP NO. (OR GROUP NAME OR FECA CLAIM NO.)

☐ INSURED IS EMPLOYED AND COVERED BY EMPLOYER HEALTH PLAN

9. OTHER HEALTH INSURANCE COVERAGE (ENTER NAME AND DATE OF BIRTH OF POLICYHOLDER. PLAN NAME AND ADDRESS AND POLICY OR MEDICAL ASSISTANCE NUMBER)

10. WAS CONDITION RELATED TO:

A. PATIENT'S EMPLOYMENT

YES ☐ ☐ NO

B. ACCIDENT

AUTO ☐ ☐ OTHER

11. SUBSCRIBER'S ADDRESS (STREET, CITY, STATE, ZIP CODE)

TELEPHONE NO.

DO NOT MARK IN SHADED AREAS

12. DATE ACCIDENT OR INJURY OCCURED

MO | DAY | YR.

13. REFERRED BY

☐ SELF ☐ OTHER–NAME _____

14. IMPORTANT: BRIEFLY DESCRIBE THE ILLNESS OR INJURY WHICH REQUIRED TREATMENT

15. DATE OF EACH SERVICE MO DA YR	16. DESCRIPTION OF SERVICE	POS	PROCEDURE CODE	MOD	MOD	PRIMARY DIAGNOSIS CODE	SECONDARY DIAGNOSIS CODE	17. CHARGE FOR EACH SERVICE	UNITS	FORCE CODE

18. IF GROUP PRACTICE: NAME OF PHYSICIAN PROVIDING SERVICE

19. TOTAL CHARGES

PROV. NAME

PROV. NO.

PIC

INDIVIDUAL PROV. NO.

ATTACH ITEMIZED BILLS FROM YOUR DOCTOR OR PROVIDER TO THIS FORM

See back of form for instructions

20. PHYSICIAN OR PROVIDER NAME & ADDRESS

NAME _____

STREET _____

CITY _____ STATE _____ ZIP _____

I authorize any hospital, physician, or other provider to release to Blue Cross and Blue Shield of Vermont any information deemed necessary to process my claim for benefits.

Signature of Subscriber _____ DATE _____

1250.01 The person Signing this form is advised that the willful making of a false or fraudulent Statement herein renders him/her liable to prosecution.

- INSTRUCTIONS -

Please Follow These Instructions Carefully and Mail Completed Form With Attachments To:

Blue Cross and Blue Shield of Vermont

P.O. Box 186

Montpelier, VT 05601-0186

- Please submit a separate claim for each patient.
- Please submit a separate claim for each doctor or provider.
- Please include the itemized bill(s) or statement(s) with each claim submitted (we cannot process your claim without this copy).

—Itemized bills must be on the provider's letterhead and include the subscriber's name, the name of the patient, the name of the person or place providing the service, the date of the service, the description of each service performed and the charge for each service. Please retain a copy for your own records; these receipts will not be returned.

—**DURABLE MEDICAL EQUIPMENT**—Receipts must include the actual purchase price of the equipment, whether rented or purchased, and a Medical Necessity form signed by the doctor or provider.

—**AMBULANCE SERVICES**—Receipts must include an Ambulance Medical Necessity Form and the mileage accrued.

—**SPECIAL NURSING SERVICES**—Receipts must show the professional status of the nurse such as RN, LPN, etc., and the hours worked (day or night).

Please submit your claim as soon as any medical expenses are incurred.

Questions or Problems?

If you have any questions regarding the completion of this form, please contact the Customer Service Department toll-free at 1-800-247-2583 Montpelier area subscribers, please call (802) 223-3494; Out of state, please call I-800-457-6648.