

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)	5. PATIENT'S SEX MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>	6. SUBSCRIBER'S I.D. NO. VT
TELEPHONE NO.	7. PATIENT'S RELATIONSHIP TO SUBSCRIBER SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER <input type="checkbox"/>	8. SUBSCRIBER'S GROUP NO. (OR GROUP NAME OR FECA CLAIM NO.) <input type="checkbox"/> 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 <input type="checkbox"/> NO <input type="checkbox"/> B. ACCIDENT AUTO <input type="checkbox"/> OTHER <input type="checkbox"/>	11. SUBSCRIBER'S ADDRESS (STREET, CITY, STATE, ZIP CODE) TELEPHONE NO.
12. DATE ACCIDENT OR INJURY OCCURED MO DAY YR.	13. REFERRED BY <input type="checkbox"/> SELF <input type="checkbox"/> OTHER-NAME _____	DO NOT MARK IN SHADED AREAS

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			PRIMARY DIAGNOSIS CODE	SECONDARY DIAGNOSIS CODE	17. CHARGE FOR EACH SERVICE	UNITS	FORCE CODE
			MOD	MOD	MOD					

18. IF GROUP PRACTICE: NAME OF PHYSICIAN PROVIDING SERVICE	19. TOTAL CHARGES	PROV. NAME
ATTACH ITEMIZED BILLS FROM YOUR DOCTOR OR PROVIDER TO THIS FORM See back of form for instructions	INDIVIDUAL PROV. NO.	PROV. NO. PIC
	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 1-800-457-6648.