

INSTRUCTIONS

1. You may need your healthcare provider to assist and supply information in completing this form, including the procedure code(s) and diagnosis code(s). Please also refer to the Help Sheet for additional information.
2. To request reimbursement, please submit the following to the address listed at the end of this form (any missing information may result in delay or denial of the request):
 - a. This completed and signed claim form.
 - b. Proof of services rendered.
 - c. Proof of payment for the services being requested for reimbursement.
3. Reimbursement will be sent to the member at the address Capital Blue Cross has on record. If you believe your address is different than the address of record, please call Member Services at **866.987.4213** (TTY: 711) for Capital Blue Cross Medicare Advantage PPO and **800.779.6962** (TTY: 711) for Capital Blue Cross Medicare Advantage HMO.
4. Retain a copy of all receipts and documentation for your records.

MEMBER INFORMATION

Member ID#	Date of Birth (MM/DD/YYYY)	
Member's last name	First name	Middle initial

CLAIM INFORMATION

Healthcare provider's name	Setting where treatment was received	Phone number	Tax ID number or National Provider Identifier (NPI)
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Address of healthcare provider	Were services received outside of the U.S.? <input type="checkbox"/> No, proceed to the next section <input type="checkbox"/> Yes, answer the following questions: In what country was the patient seen? In what language was the bill written? In what currency was the bill paid?
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Diagnosis codes (if known)	Diagnosis description (e.g., flu, broken leg, asthma)	Date(s) of service	Procedure codes for each service provided (if known)	Procedure descriptions (e.g., X-ray, office visit, lab work, leg cast)	Amount paid
		/ /			\$
		/ /			\$
		/ /			\$
		/ /			\$
		/ /			\$
		/ /			\$

Total amount paid \$

Attach another sheet if more services are reported.

Member or personal representative signature is required.

I attest that the above information is true and accurate and that the services were received and paid for in the amount requested as indicated above. I acknowledge that if any information on this form is misleading or fraudulent my coverage may be canceled and I may be subject to criminal and/or civil penalties for false healthcare claims. I also understand that Capital Blue Cross may request any additional information it deems necessary to verify that services were received and payment was made.

Printed name

Signature

Date



Please submit this form and all documentation to:

Medicare Advantage
PO Box 211457
Eagan, MN 55121-3057

Capital Blue Cross is an HMO, PPO plan with a Medicare contract. Enrollment in Capital Blue Cross depends on contract renewal. Care management services for certain products are provided by WellSpan Health.

Capital Blue Cross is an independent licensee of the Blue Cross Blue Shield Association.

Communications issued by Capital Blue Cross in its capacity as administrator of programs and provider relations for all companies.

MEMBER MEDICAL CLAIM FORM HELP SHEET

FIELD NAME	DESCRIPTION
Member's ID#	Capital Blue Cross ID number, found on the front of the Capital Blue Cross ID card.
Member's name	Last and first names and middle initial of member who received services.
Member's date of birth	Date of birth: MM/DD/YYYY
Provider's name, address, phone number, tax ID number, or National Provider Identifier (NPI)	A provider includes, but is not limited to, hospitals, physicians, optometrists, psychiatrists, licensed clinical social workers, durable medical equipment suppliers, and pharmacies (for covered items that are not submitted to your pharmacy vendor).
In what setting did the patient receive treatment?	Such as office, emergency room, outpatient hospital (for X-rays, tests), inpatient hospital, clinic, medical supply store.
If services were rendered outside of the U.S.	If applicable, indicate in what country services were provided, in what language (if not English) the bill and proof of payment were written, and in what currency the bill was paid.
Diagnosis: what was the patient seen for?	Provide a diagnosis code (if known) and detailed description of illness or injury (e.g., flu, broken leg, manic-depressive disorder, asthma).
Date(s) of service	The date(s) the services were provided to the patient.
Procedures, services, or supplies provided	Provide a procedure code (if known) and detailed description (e.g., X-ray, office visit, lab work, leg cast).
Total amount paid	Total amount for which you are requesting reimbursement.
Proof of service(s)	A document that demonstrates the service was actually rendered, listing date(s) of service, service(s) provided, and dollar amounts paid.
Proof of payment	A document that demonstrates payment made by the member was received by the provider of service. Examples include: the front and back of the canceled check written to the provider or the bank encoded front of the check written to the provider; a credit card statement or receipt; a statement from the provider on the provider's letterhead with authorized signature indicating payment was made; a receipt for purchased items with the provider's name and address preprinted on the receipt with items listed and amount paid.

PROOF OF SERVICE AND PROOF OF PAYMENT EXAMPLES

Jane Doe, M.D.
County Medical
1234 Any Street
Anytown, MA 12345

Telephone: 555-555-7894
Tax ID# XX-XXXXX

For: Susan Sample

Diagnosis Code V.0208, Procedure Code 45678 for 1/23/12 and 2/16/12

\$25 per visit
\$50 total

PAID IN FULL

Jane Doe, M.D.
LIC # 11122567

This example demonstrates both proof of payment and proof of service.

1838

SUSAN SAMPLE
10 MAIN STREET
ANYTOWN, MA 12345

DATE 3/17/12

PAY TO THE ORDER OF County Medical \$ 50.00

Fifty and 00/100 DOLLARS

LOCAL BANK

MEMO 001240 *Susan Sample*

⑆ 323456789 ⑆ 12345678901011 1838

NATIONAL BANK 012345678
4/18/2012
16:33:06
12345
ABGGRD

FOR DEPOSIT ONLY
001234567

ENDORSE HERE

This example demonstrates proof of payment.