

**IMPORTANT, PLEASE READ THE FOLLOWING: Claims must be submitted with the timeframe specified by your contract.**

**HOW TO SUBMIT YOUR CLAIM:**

1. Complete a separate Subscriber Claim Form for each patient and for each provider.
2. Answer all questions.
3. Attach a copy of the **itemized bill**. The bill should show:
  - the provider's name and address and Federal tax ID or National Provider Identifier (NPI)
  - the diagnosis or the symptoms of illness
  - the date, place and type of service
  - the charge for each service
4. Attach a copy of your Explanation of Health Care Benefits, if you have other coverage as primary.

NOTE: We cannot return the claim or documentation that you send. Please make copies for your personal files.

**Mail this form to:**

Blue Cross and Blue Shield of Minnesota  
PO Box 64338  
St. Paul, MN 55164-0338

**Fax this form to:**

651-662-7933

**Email this form to:**

[ISC\\_Subscriber\\_Claims@bluecrossmn.com](mailto:ISC_Subscriber_Claims@bluecrossmn.com)



# SUBSCRIBER CLAIM FORM

This claim form must be completed using **Black ink**.

Blue Cross\* and Blue Shield\* of Minnesota and Blue Plus\* are nonprofit independent licensees of the Blue Cross and Blue Shield Association

IDENTIFICATION NUMBER		GROUP NUMBER		<b>COPY THE INFORMATION FROM YOUR BLUE CROSS AND BLUE SHIELD OF MINNESOTA MEMBER ID CARD</b>			
SUBSCRIBER'S LAST NAME		SUBSCRIBER'S FIRST NAME					
				MO	DAY	YR	
PATIENT'S LAST NAME		PATIENT'S FIRST NAME		PATIENT'S BIRTHDATE			
				MO	DAY	YR	
PATIENT'S SEX		PATIENT'S RELATIONSHIP TO SUBSCRIBER			IS CONDITION JOB RELATED?		
<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		<input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> UNMARRIED DEPENDENT			<input type="checkbox"/> YES <input type="checkbox"/> NO		
SUBSCRIBER'S STREET ADDRESS				CITY	STATE	ZIP CODE	FOREIGN CLAIM?
							YES <input type="checkbox"/> NO <input type="checkbox"/>
IS THIS SERVICE RELATED TO:				MO.	DAY	YR.	IF ILLNESS, DATE OF FIRST SYMPTOM IF INJURY or ACCIDENT, DATE OF INJURY or ACCIDENT IF MATERNITY, DATE OF LAST MENSTRUAL PERIOD
<input type="checkbox"/> ILLNESS <input type="checkbox"/> INJURY <input type="checkbox"/> MATERNITY <input type="checkbox"/> AUTO ACCIDENT							
IF HOSPITALIZED:		ADMISSION DATE		DISCHARGE DATE		NAME OF ADMITTING PHYSICIAN	
		MO	DAY	YR.	MO.	DAY	YR.
							NAME OF HOSPITAL
SYMPTOMS AND/OR DIAGNOSIS							
NAME OF PROVIDER				PROVIDERS ADDRESS			
<b>OTHER COVERAGE INFORMATION</b>							
For claims related to an injury or auto accident, please provide the name and address of the other carrier, if applicable.						<b>YOU MUST INCLUDE A COPY OF YOUR EXPLANATION OF BENEFITS</b> , if you have other health care insurance as primary coverage, have an auto or worked related injury, or have Medicare benefits	
IDENTIFICATION NUMBER _____		GROUP NUMBER _____					
NAME OF INSURANCE COMPANY _____							
ADDRESS _____							
Does the patient have other insurance coverage? Yes <input type="checkbox"/> No <input type="checkbox"/>						Does the patient have Medicare Coverage: Yes <input type="checkbox"/> No <input type="checkbox"/>	
IDENTIFICATION NUMBER _____		GROUP NUMBER _____				MEDICARE NUMBER _____	
NAME OF INSURANCE COMPANY _____						Is the patient eligible for Medicare Part A? Yes <input type="checkbox"/> No <input type="checkbox"/>	
ADDRESS _____						Is the patient eligible for Medicare Part B? Yes <input type="checkbox"/> No <input type="checkbox"/>	
I hereby certify that the statements provided by me are correct and acknowledge that I will refund to Blue Cross and Blue Shield of Minnesota duplicate payments to myself from other sources because of coordination of benefits. I authorize the provider of services, named above, to release the information requested on this form to Blue Cross and Blue Shield of Minnesota. <b>A person who files a claim with the intent to defraud or helps commit a fraud against an insurer is guilty of a crime.</b>							
Signature _____				Date Signed _____			

