**Subscriber Claim Form**

**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

<table>
<thead>
<tr>
<th>Identification Number (including alpha prefix)</th>
<th>Last Name</th>
<th>First Name</th>
<th>Middle Initial</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address-Number &amp; Street</td>
<td>City</td>
<td>State</td>
<td>Zip Code</td>
</tr>
<tr>
<td>Date of Birth (MM/DD/YY)</td>
<td>Employer’s Name</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Patient Information

<table>
<thead>
<tr>
<th>Patient Last Name</th>
<th>First Name</th>
<th>Middle Initial</th>
<th>Date of Birth (MM/DD/YY)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Gender</th>
<th>Patient is:</th>
<th></th>
<th>Was treatment for:</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Male</td>
<td>☐ Subscriber (contract holder)</td>
<td>☐ Spouse (to contract holder)</td>
<td>☐ Child (age 18 or younger)</td>
</tr>
<tr>
<td>☐ Female</td>
<td>☐ Student (age 19 or older)</td>
<td>☐ Handicapped Dependent (age 19 or older)</td>
<td></td>
</tr>
</tbody>
</table>

**Does the patient have other insurance:** ☐ Yes ☐ No

**Effective Date:**

<table>
<thead>
<tr>
<th>Medicare Part A (Hospital)</th>
<th>☐ Yes ☐ No <em><strong>/</strong></em>/___</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare Part B (Medical)</td>
<td>☐ Yes ☐ No <em><strong>/</strong></em>/___</td>
</tr>
<tr>
<td>Medicare Part D (Pharmacy)</td>
<td>☐ Yes ☐ No <em><strong>/</strong></em>/___</td>
</tr>
<tr>
<td>Other Blue Cross Blue Shield Membership?</td>
<td>☐ Yes ☐ No <em><strong>/</strong></em>/___</td>
</tr>
<tr>
<td>Other Insurance Plan?</td>
<td>☐ Yes ☐ No <em><strong>/</strong></em>/___</td>
</tr>
</tbody>
</table>

**Identification Number:**

**Name and address of other insurance:**

**Subscriber Signature:**

**Date:**

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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

<table>
<thead>
<tr>
<th>Procedure Code(s)</th>
<th>Units</th>
<th>Procedure Description</th>
<th>Date of Service</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>92507</td>
<td>1</td>
<td>Speech–Language Therapy</td>
<td>10/5/2008</td>
<td>$72.50</td>
</tr>
<tr>
<td>92507</td>
<td>2</td>
<td>Speech–Language Therapy</td>
<td>11/3/2008</td>
<td>$145.00</td>
</tr>
</tbody>
</table>

Diagnosis Codes: 784.50, 315.31

Provider Credentials: Jane Johnson, SLP, CCC  
Speech-Language Pathologist  
License #: Y777777

Patient Name: Joan Smith  
Referring Doctor: Dr. John Jones  
Tax ID/NPI: 99-9999999

**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/](http://www.bluecrossma.com/wps/portal/members/). If you have not already registered for Member Central, click Create an Account and follow the directions.