Member Claim Form

Do not file prescription drugs on this form. Use blue or black ink to complete.

☐ **Check box** if filing for glasses, contact lenses or diabetic supplies.

- Please indicate where services were rendered if not in North Carolina: _____
- Visit ***www.shpnc.org*** for prescription drug claim forms, ***bcbsnc.com*** for international claim forms, or call the toll free number on your ID card.

Filing Requirements:

Any claim filed without the required documentation listed below will be returned.

- Complete a separate claim form for each covered family member.
- Enclose itemized receipts and make copies for your records. See Section IV for required information.
- Do not file a claim if the provider is filing for the same services.
- Attach Explanation of Benefits if these services are covered by another insurance policy.
- Claims must be filed within 18 months from the date services were received, or they will be denied.
- Please see Section VI for mailing information.

SECTION I: Patient Information

Please enter the subscriber number from your ID card.

Subscriber Number: **Begin with 4-letter prefix** ☐☐☐☐☐☐☐☐☐☐☐☐☐☐–☐☐ **2 digits following patient's name** ***(see ID card)***

Patient's Last Name: _____ First Name: _____ Middle Initial: _____

Date of Birth: ☐☐-☐☐-☐☐☐☐

Sex: ☐ Male ☐ Female

Relationship to Subscriber: ☐ Self ☐ Child ☐ Spouse ☐ Other: _____

SECTION II: Mailing Information

☐ Please check here if address has changed.

Subscriber Name: _____

Address (Line 1): _____

Address (Line 2): _____

City: _____ State: _____ ZIP Code: _____

SECTION III: Other Insurance Information

Please complete the information below if the patient is covered by another health insurance policy.

Does the patient have other insurance? ☐ Yes ☐ No

Other health insurance company name: _____

Other policy number: _____

Other policy holder's name: _____

Other policy holder's employer name: _____

Please complete the information below if the patient is covered by Medicare:

Medicare health insurance claim number: _____

Is patient eligible for: ☐ Part A ☐ Part B ☐ Part A and B

PLEASE NOTE: If your other insurance or Medicare policy is primary, you must attach a copy of the Explanation of Benefits from that insurer. Your claim cannot be processed without this information.

BlueCross BlueShield of North Carolina

North Carolina State Health Plan
FOR TEACHERS AND STATE EMPLOYEES
A Division of the Department of State Treasurer

North Carolina HealthSmart

SECTION IV: Services and Supplies To Be Considered For Reimbursement

These may include ambulance services, medical appliances, diabetic supplies, glasses and/or contact lenses or out-of-network services.

BCBSNC requires that procedure codes and diagnosis codes on the itemized receipt be supplied by the provider of the service. Claims or itemized receipts received without the information below will be RETURNED.

If services were rendered outside of the USA, please indicate: Country: _____ **Currency Used:** _____

Date of Service (MM/DD/YY)	Procedure Codes or Description of Service/Supplies	Diagnosis Codes or Symptoms You Sought Treatment For	Charge
01-05-07	EXAMPLE: Office Visit	Cold and Flu Symptoms	$54.00

SECTION V: Private Duty Nursing

Enclose a copy of your receipts for these services.

Date of Service (MM/DD/YY)	Name of Nurse	Indicate RN, LPN or CNA	License Number	Hours Worked	Charge
03-10-07	EXAMPLE: Ms. Jane M. Doe	LPN	123456	8	$160.00

SECTION VI: Mailing Information

MAIL THIS FORM, ITEMIZED RECEIPTS AND EXPLANATION OF BENEFITS *(if applicable)* TO:

Blue Cross and Blue Shield of North Carolina
P.O. Box 30087
Durham, NC 27702

If a claim is for prescription drugs or insulin that are not being filed for you, please complete a prescription drug claim form and mail to:

CVS Caremark
P.O. Box 52136
Phoenix, Arizona 85072-2136

DID YOU REMEMBER TO:

- Use blue or black ink to complete the form?
- Attach the Explanation of Benefits, if applicable?
- Attach itemized receipts?
- Provide your signature below?
- Keep a copy of this form and your receipts?

I certify that the information on this form is correct and the expenses incurred were necessary for the services filed.

Signature: _____ **Date:** _____ **Daytime Phone Number:** _____