



MASSACHUSETTS

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

Identification Number (including alpha prefix)	Last Name	First Name	Middle Initial
Address-Number & Street		City	State Zip Code

Date of Birth
MM DD YY Employer's Name

Patient Information			
Patient Last Name	First Name	Middle Initial	Date of Birth MM DD YY
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Patient is: <input type="checkbox"/> Subscriber (contract holder) <input type="checkbox"/> Spouse (to contract holder) <input type="checkbox"/> Child (Age 18 or younger) <input type="checkbox"/> Student (age 19 or older) <input type="checkbox"/> Handicapped Dependent (Age 19 or older) <input type="checkbox"/> Other (Specify) _____		

Does the patient have other insurance: <input type="checkbox"/> Yes <input type="checkbox"/> No Medicare Part A (Hospital) <input type="checkbox"/> Yes <input type="checkbox"/> No _____/_____/_____ Medicare Part B (Medical) <input type="checkbox"/> Yes <input type="checkbox"/> No _____/_____/_____ Medicare Part D (Pharmacy) <input type="checkbox"/> Yes <input type="checkbox"/> No _____/_____/_____ Other Blue Cross Blue Shield Membership? <input type="checkbox"/> Yes <input type="checkbox"/> No _____/_____/_____ Other Insurance Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No _____/_____/_____ Identification Number: _____ Name and address of other insurance: _____	Effective Date: Was treatment for: Accident at work? <input type="checkbox"/> Yes <input type="checkbox"/> No Date of Accident _____/_____/_____ Auto accident? <input type="checkbox"/> Yes <input type="checkbox"/> No Date of Accident _____/_____/_____ If yes, name of auto insurance: _____ Policy Number: _____ Other accident? <input type="checkbox"/> Yes <input type="checkbox"/> No Date of Accident _____/_____/_____ _____
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Subscriber Signature: _____

Date: _____ | |

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

To: Joe Smith
15 Elm St.
Anytown, MA 12345

Patient Name: Joan Smith
Referring Doctor: Dr. John Jones

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

Provider
Credentials

Tax ID/NPI: 99-9999999

Procedure Code(s)	Units	Procedure Description	Date of Service	Amount	Itemized Charges
92507	1	Speech – Language Therapy	10/5/2008	\$72.50	
92507	2	Speech – Language Therapy	11/3/2008	\$145.00	
Diagnosis Codes: 784.50, 315.31				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:
 - a. Provider name
 - b. Provider address
 - c. Provider Tax ID/NPI
 - d. 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:
 - a. National Drug Code (NDC)
 - b. Name of drug
 - c. Date dispensed
 - d. Quantity dispensed
 - e. Name of prescribing physician

To view processed claims, visit our website www.bluecrossma.com/member/service. If you have not already registered in Member Self Service, choose the **Register Now** option and follow the directions.