Blue Cross of Idaho®

MEMBER CLAIM FORM

Street Address:
3000 E. Pine, Meridian, ID 83642-5995
Mailing Address:
P.O. Box 7408, Boise, ID 83707-1408
(208) 345-4550

This form must be completed for all Blue Cross of Idaho member submitted claims. A receipt of payment may be requested before the claim is processed. To eliminate any delays, please attach a copy of the receipt.

1. If any of the services were related to an accident, the ACCIDENTAL INJURY INFORMATION section below must also be completed. Failure to do so could result in delayed processing of your claim.
2. Circle the charges on your provider's statement that you are submitting and staple the statement to the form. The provider's statement must indicate: the individual provider's name or NPI number, a procedure code and diagnosis code for each service provided, the date the service was furnished, and the charge for each service. Submit a separate member claim form for each different provider.
3. To file charges for more than one patient, even if the charges are all on one bill, please:
   a. Complete a separate form for each patient AND attach a separate copy of the provider's bill to each patient's form, if needed.
   b. If a claim is submitted for services rendered by an out of state provider, we may forward your claim to the appropriate Blue Cross Blue Shield Plan to be processed.
4. Mail all forms to the mailing address in the upper right corner of this form.
5. For prescription drug claims, the pharmacy receipt must include the NDC number, name of drug, quantity and dosage. For members with a Pharmacy Benefits Manager (PBM) such as CVS Caremark, pharmacy reimbursement may need to be sent to PBM directly. Additional information about your PBM may be found on the back of your membership ID card.

You should hear from us within 30 days upon receipt by our Plan. Please do not re-submit these charges to us in the meantime.

PATIENT AND ENROLLEE INFORMATION

Patient's Name *(First Name, Middle Initial, Last Name)*

Patient's Date of Birth

Enrollee's Name *(First Name, Middle Initial, Last Name)*

Do you or any of your dependents have other health coverage? *(This includes other Blue Cross and Blue Shield coverage as well as Medicare.)*
☐ YES ☐ NO
Type of Coverage ☐ Medical ☐ Dental ☐ Vision
If Medicare ☐ Part A ☐ Part B ☐ Part D

Patient's Sex
☐ Male ☐ Female

Enrollee's Blue Cross of Idaho Identification Number *(with Alpha Prefix)*

Patient's Relationship to Enrollee
☐ Self ☐ Spouse ☐ Child ☐ Other

Enrollee's Group No. *(or Program Number)*

Coverage is for *(Check all applicable boxes)*
☐ Enrollee ☐ Spouse ☐ Children

Name and Address of Other Carrier

ID Number with Other Carrier

Group Number/Name with Other Carrier

Enrollee's Address *(Street, City, State, Zip Code)*

Was this condition the result of an accident?
☐ YES ▼ ☐ NO ► If NO, enter date of service, sign at the bottom, and return the form to us.

Date of Service

Effective Date with Other Carrier

ACCIDENTAL INJURY INFORMATION *(Please complete if claim is related to an injury)*

Date of Injury mm/dd/yy

Describe how and where the injury occurred.

To your knowledge, who was responsible for the accident?

Have you received settlement from the responsible party?
☐ YES ☐ NO

Do you intend to make a claim against the responsible party?
☐ YES ☐ NO ☐ POSSIBLY

Is an attorney representing you in this matter? If so, please give your attorney's name and address. *(Blue Cross of Idaho may be contacting your attorney regarding this matter.)*

Was the condition the result of an auto accident?
☐ YES ☐ NO

Was this injury or illness sustained while performing work required by the patient's employment?
☐ YES ☐ NO (If your claim is work-related and you have received a denial please attach a copy.)

Is the patient covered by Workers' Compensation?
☐ YES ☐ NO

Is the patient self-employed?
☐ YES ☐ NO

Has the patient filed a claim with the Industrial Accident Commission?
☐ YES ☐ NO

Has the patient notified his or her employer of this condition?
☐ YES ☐ NO

Is the patient covered by a liability coverage other than Workers' Compensation for work-incurred injuries?
☐ YES ☐ NO

Has the patient filed a claim with his or her employer's liability coverage?
☐ YES ☐ NO

Signature of Enrollee

Make Payment to ☐ Enrollee *(Attach proof of payment)* ☐ Provider

Date Submitted

WARNING: *Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information, is guilty of a felony. In cases of proven fraud, Blue Cross of Idaho will terminate agreements for services and benefits, seek restitution of dollars lost, and pursue criminal prosecution to the full extent of the law.*

THANK YOU FOR YOUR HELP

Form No. 5-175 (06-15)