

Member Claim Form

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

- Visit bcbsnc.com for prescription drug, dental and international claim forms, or call the toll-free number on your ID card.

Filing Requirements:

- 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.

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

SECTION I: Patient Information		Please enter the subscriber number from your ID card.	
Subscriber Number:	Begin with letter prefix	<input type="text"/>	2 digits following member's name (see ID card)
Patient's Last Name: _____		First Name: _____ Middle Initial: _____	
Date of Birth:	Sex:	Relationship to Subscriber:	
<input type="text"/>	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Self <input type="checkbox"/> Child <input type="checkbox"/> Spouse <input type="checkbox"/> Other: _____	

SECTION II: Mailing Information		<input type="checkbox"/> Please check here if address has changed.	
Subscriber Name: _____			
Address (Line 1): _____			
Address (Line 2): _____			
City: _____	State: NC	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?	<input type="checkbox"/> Yes <input type="checkbox"/> 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: <input type="checkbox"/> Part A <input type="checkbox"/> Part B <input type="checkbox"/> 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.

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