



Complete a separate claim form for each patient. Please print.

- Confidential -

## Subscriber Information - Complete for all claims.

Subscriber Name:

\_\_\_\_\_  
Last First MI

Address:

\_\_\_\_\_  
Street

\_\_\_\_\_  
City State ZIP Code

Telephone Number: Work: (\_\_\_\_\_) \_\_\_\_\_

Subscriber Identification Number:

\_\_\_\_\_  
(from your card)

Spouse's Employer (if applicable):

\_\_\_\_\_  
Name of Employer

\_\_\_\_\_  
City State

Home: (\_\_\_\_\_) \_\_\_\_\_

## Patient Information - Complete for all Claims - All statements must be completed.

Patient Name:

\_\_\_\_\_  
Last First MI

Patient Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
MM DD YYYY

Patient is:

- Subscriber
- Spouse
- Dependent Child
- Other

If patient is a dependent child age 19 or over (at the time of service), please indicate:

- Full-time Student  
Name of School: \_\_\_\_\_
- Handicapped

Is patient eligible for Medicare?

- No
- Yes - See instructions on back.

Is patient covered under any other group health insurance plan except Medicare?

- No
- Yes - Give name, address and policy number of other health insurance company. See instructions on back.

\_\_\_\_\_  
Name of Insurance Company

\_\_\_\_\_  
Policy Number

\_\_\_\_\_  
City State

## Accident Information - Complete only if claim is due to an accident.

Place of Accident:

\_\_\_\_\_  
City State

Date of Accident: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
MM DD YYYY

Accident was:

- Job Related
- Motor Vehicle Related
- Other - Briefly Explain: \_\_\_\_\_

## Authorization - Complete for all claims.

Pay benefits for this claim:  To me, the subscriber.  
 Directly to the provider of service (hospital, physician, skilled nursing facility, etc.).

1. I hereby authorize any hospital, insurance company, or any other provider of services to release any information requested with respect to this claim and attached bills.
2. I certify that the information on this claim and the attached bills is complete and true.
3. I understand it is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Filing Instructions  
(See Reverse Side)

# Instructions for Filing Claims to BlueCross BlueShield of Tennessee

**Members: Use the following procedure when your provider does not file a claim. This information applies to physician, hospital, dental, prescription and vision claims. Note: Providers in our networks are required to file claims for you.**

**1.** If your health care provider does not file claims, ask the provider for a claim form you can use to file it yourself. If the provider cannot give you a claim form, contact the BlueCross BlueShield of Tennessee service unit to request one. The phone number is on your ID card.

**2.** To file a claim yourself, fill out all the basic information on the front page of the form. If you obtain a claim form from BlueCross BlueShield of Tennessee, it will specify this information is needed. If you obtain a claim form from the provider, it may or may not ask for all this information. If it does not, be sure to include this information in a separate document to help speed the accurate processing of the claim. The basic information required on the claim form should include at least the following information. **Please print:**

## Subscriber Information:

- Subscriber name, address, telephone number.
- Subscriber identification number. This will be on your BlueCross BlueShield of Tennessee identification card. Be sure to include any alpha prefix.

## Patient Information:

- Patient name, date of birth.
- Note whether the patient is the subscriber, spouse, dependent child, or other.
- If the patient is a dependent child age 19 or over at the time of the service, note if the patient is a full-time student by checking the box provided. Include the name of the school. If the dependent is handicapped, check the box provided.
- Note if the patient is covered under any other group health insurance policies, except Medicare. If yes, specify the name of the other insurance company; policy number; and city and state of the other insurance company. Attach a copy of the Explanation of Benefits (EOB) from the other insurance plan.
- Note if the patient is eligible for Medicare.
- If the patient is eligible for Medicare, attach a copy of the Explanation of Benefits (EOB) received from Medicare for all services related to the claim.

## Accident Information:

- Please indicate if the claim is due to an accident. If it is, please note the following:
  - place of accident
  - city and state;
  - date of accident;
  - note if the accident was job-related, motor-vehicle related, or other (if other, include a brief explanation).

## Authorization Information:

- Note authorization instructions for payment. Note if the claim should be paid to you or directly to the provider of the service.
- Sign and date the claim form.

**3.** Attach to the claim form all itemized bills related to this claim. The physician or facility where the service was rendered should provide you with such bills. The itemized bills should include:

- the name and address of the physician or other provider of service;
- the name of the patient;
- the date of each service;
- the procedure code for each service (your provider can supply these codes) and
- the amount of charge for each service (cancelled checks, cash register receipts, money orders, credit card vouchers, personal list of services or bills only stating "balance forward" are not acceptable substitutes for itemized bills).

**Note: Please keep for your records copies of all information forwarded to BlueCross BlueShield of Tennessee.**

**4. Mail the completed claim form and attachments to:**

**BCBST Claims Service Center  
1 Cameron Hill Circle, Suite 0002  
Chattanooga, Tennessee 37402-0002**

**After your claim is processed, BlueCross BlueShield of Tennessee will send you an Explanation of Benefits (EOB) and a check (if you are due money).**