



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 Effective Date: ____/____/____ 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: _____		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
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.