Member Claim Form Requirements

Please note the below filing requirements and tips for filling out the attached Member Claim Form. Do not file prescription drugs or dental claims with this form.

Visit **shpnc.org/employee-benefits/important-forms** for prescription drug and international claim forms, or call the toll-free number on your ID card.

Important Notes When Completing the Claim Form:

- Type or use blue or black ink to complete
- Complete a separate claim form for each covered family member
- Complete a separate claim form for each provider
- Attached receipts must include procedure codes and diagnosis codes (such as CPT/Dx codes), individual cost for each service, and the provider's name, address and Tax ID
- Do not file a claim if the provider is filing for the same services or if the provider is in-network
- 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
- If your address has recently changed, please contact Customer Service using the phone number located on the back of your ID card to ensure our records are accurate
- Keep a copy of this form and your receipts
- Remember to sign and date at the bottom of Section 5

Please note: Claim form will be returned to member if provider receipts are not attached with the form!

Member Claim Form

SECTION 1: Patient Information
Please enter the subscriber number from your ID card.

Subscriber Number: **Begin with Letter Prefix** ☐☐☐☐☐☐☐☐☐☐☐☐ – ☐☐ **2 Digits Following Member's Name** (see ID card)

Patient's Last Name: _____ First Name: _____ Middle Initial: _____

Date of Birth: ☐☐ – ☐☐ – ☐☐☐☐

Sex: ☐ Male ☐ Female

Relationship to Subscriber: ☐ Self ☐ Child ☐ Spouse ☐ Other: _____

SECTION 2: Mailing Information

Subscriber Name: _____

Address (Line 1): _____

City: _____ State: ☐☐ Zip Code: ☐☐☐☐☐ – ☐☐☐☐

SECTION 3: Other Insurance Information
Please complete the information below if the patient is covered by another health insurance policy.

Does the Patient have Other Insurance? ☐ Yes ☐ 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: (check all that apply) ☐ Part A ☐ Part B ☐ Part C

SECTION 4: International Information
Please complete the information below if the provider or services rendered were out of the United States.

Country: _____ **Currency Used:** _____

SECTION 5: Submitting Form Information

MAIL, FAX OR EMAIL THIS FORM, ITEMIZED RECEIPTS AND EXPLANATION OF BENEFITS (if applicable) TO:

MAIL: Blue Cross and Blue Shield of North Carolina
P.O. Box 30087, Durham, NC 27702
FAX: 1-866-990-1385
EMAIL: MemberClaimsSubmission@bcbsnc.com

FOR ALL PRESCRIPTION DRUGS OR INSULIN THAT ARE NOT BEING FILED BY YOUR PROVIDER, PLEASE COMPLETE A PRESCRIPTION DRUG CLAIM FORM AND MAIL TO:

CVS Caremark
P.O. Box 52136
Phoenix, Arizona 85072-2136

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.

I certify that the information on this form is correct and the expenses incurred were necessary for the services filed.

Signature: _____ Date: _____ Daytime Phone Number: _____