MEMBER CLAIM FORM

Use this form to file Smoking Cessation Claims

TIPS FOR FILING:
- Claims must be filed within 18 months from the date services were received or they will be denied for late filing.
- Complete a separate claim form for each covered family member.
- Type or print legibly.
- Enclose receipts and make copies for your records.

- Do not file a claim if the Provider or Hospital is filing for the same services.
- Attach Explanation of Benefits if these services are covered by another group health policy.
- Mailing instructions are included on the back of this form.

SECTION I: PATIENT INFORMATION

SUBSCRIBER NUMBER

BEGIN WITH 1
ALPHA PREFIX

PATIENT LAST NAME
FIRST NAME
MI

PATIENT DATE OF BIRTH

PATIENT SEX
■ MALE
■ FEMALE

PATIENT RELATIONSHIP TO SUBSCRIBER
■ SELF
■ CHILD
■ SPOUSE
■ OTHER

SECTION II: SUBSCRIBER INFORMATION

SUBSCRIBER NAME

ADDRESS (LINE 1)

ADDRESS (LINE 2)

CITY
STATE
ZIP CODE

■ PLEASE CHECK HERE IF ADDRESS HAS CHANGED

SECTION III: OTHER INSURANCE INFORMATION

PLEASE COMPLETE THE INFORMATION BELOW IF THE PATIENT IS COVERED BY ANOTHER GROUP HEALTH INSURANCE.

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:
■ PART A
■ PART B
■ PART A AND B

PLEASE NOTE: IF YOUR OTHER INSURANCE OR MEDICARE POLICY IS PRIMARY, PLEASE ATTACH A COPY OF THE EXPLANATION OF BENEFITS. 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.

SUBSCRIBER SIGNATURE
DATE

TELEPHONE NUMBER WE CAN CONTACT YOU (IF NEEDED)

Please use the reverse side of this form to provide a description of services you are filing for.

An Independent Licensee of the Blue Cross and Blue Shield Association
### SECTION IV: OTHER SERVICES AND SUPPLIES NOT FILED BY PROVIDER OR HOSPITAL

(Attach a legible copy or original itemized receipts)

These may include office visits, hospital visits, physical therapy, diabetic supplies, ambulance services, medical appliances, etc.

If services were rendered outside the USA, please indicate: **Country:**

<table>
<thead>
<tr>
<th>DATE OF SERVICE (MM/DD/YY)</th>
<th>DESCRIPTION OF SERVICE / SUPPLIES</th>
<th>DIAGNOSIS OR SYMPTOMS YOU SOUGHT TREATMENT FOR</th>
<th>CHARGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>01-05-99</td>
<td>Office Visit</td>
<td>Cold and Flu Symptoms</td>
<td>$54.00</td>
</tr>
<tr>
<td></td>
<td>Smoking</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Cessation</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>S9075</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### SECTION V: PRIVATE DUTY NURSING

Enclose a copy of your receipts for these services.

<table>
<thead>
<tr>
<th>DATE OF SERVICE (MM/DD/YY)</th>
<th>NAME OF NURSE</th>
<th>INDICATE RN OR LPN</th>
<th>LICENSE NUMBER</th>
<th>HOURS WORKED</th>
<th>CHARGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>01-05-99</td>
<td>Ms. Jane M. Doe</td>
<td>LPN</td>
<td>123456</td>
<td>8</td>
<td>$160.00</td>
</tr>
</tbody>
</table>

### SECTION VI: MAILING INFORMATION

MAIL THIS FORM TO:

Blue Cross and Blue Shield of North Carolina
PO Box 35
Durham, NC 27702

Additional claim forms can be printed from our website, BCBSNC.COM, or requested by calling customer service at the toll free number on your ID card.