BlueCross BlueShield of North Carolina

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 3 ALPHA PREFIX

2 DIGITS PRECEDING PATIENT'S NAME (Please see ID Card)

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 NECESSARY)*

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

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: _____ CURRENCY USED: _____

DATE OF SERVICE *(MM/DD/YY)*	DESCRIPTION OF SERVICE / SUPPLIES	DIAGNOSIS OR SYMPTOMS YOU SOUGHT TREATMENT FOR	CHARGE
01-05-99	EXAMPLE: Office Visit	Cold and Flu Symptoms	$54.00
	Smoking Cessation S9075	305.1	

SECTION V: PRIVATE DUTY NURSING

ENCLOSE A COPY OF YOUR RECEIPTS FOR THESE SERVICES.

DATE OF SERVICE *(MM/DD/YY)*	NAME OF NURSE	INDICATE RN OR LPN	LICENSE NUMBER	HOURS WORKED	CHARGE
01-05-99	EXAMPLE: Ms. Jane M. Doe	LPN	123456	8	$160.00

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.