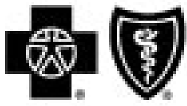

4000 House Avenue • P. O. Box 2266
Cheyenne, WY 82003-2266

An independent licensee of the Blue Cross
and Blue Shield Association.

MEDICAL CLAIM FORM

(Instructions for filing on second page)

PARTICIPANT'S NAME *(Last, First, Middle)*	ALPHA PREFIX ☐☐☐ BCBS CARD NUMBER ☐☐☐☐☐☐☐☐☐

HOME ADDRESS *(Street, City, State, Zip)*	IS THIS A NEW ADDRESS? ☐ YES ☐ NO

PATIENT'S NAME *(Last, First, Middle)*	☐ MALE ☐ FEMALE	DATE-OF BIRTH _____/_____/_____ Month / Day / Year	RELATIONSHIP TO PARTICIPANT	☐ SELF ☐ SPOUSE ☐ CHILD

DESCRIBE THE ILLNESS, INJURY OR SYMPTOMS REQUIRING TREATMENT ____

IF ILLNESS OR INJURY RESULTED FROM AN ACCIDENT, WAS IT DUE TO: AUTO ☐ EMPLOYMENT ☐ OTHER ☐	INDICATE DATE OF ACCIDENT _____/_____/_____

IF OTHER, BRIEFLY DESCRIBE ____

IF CLAIM FOR DEPENDENT CHILD OVER AGE 19, ARE THEY: ☐ FULL-TIME-STUDENT ☐ PART TIME STUDENT ☐ OTHER	IF STUDENT, PLEASE GIVE NAME & LOCATION OF SCHOOL ATTENDING: DATE OF SCHOOL ENROLLMENT:

OTHER HEALTH INSURANCE:
Is the patient covered by additional health insurance through an employer, a group such as a professional organization or any other group health insurance, including other Blue Cross and/or Blue Shield Coverage? ☐ YES ☐ NO
If yes, please complete this section.

NAME AND ADDRESS OF INSURING COMPANY *(Street, City, State, Zip)*	EFFECTIVE DATE _____/_____/_____ Month / Day / Year	TERMINATION DATE _____/_____/_____ Month / Day / Year

NAME OF POLICYHOLDER *(Last, First, Middle)*	DATE-OF-BIRTH _____/_____/_____ Month / Day / Year	IDENTIFICATION NUMBER *(Including all letters & numbers)*

POLICYHOLDER'S EMPLOYER
F EMPLOYMENT, PLEASE GIVE NAME AND ADDRESS OF EMPLOYER ____

I certify that the above is correct and complete and that I am claiming benefits only for the charges incurred by the patient named above.

______________________________   ____________________
Signature of Participant   Date

INSTRUCTIONS FOR FILING CLAIMS

1. A separate claim form must be submitted for each family member.

2. Itemized bills for covered services, supplies and durable medical equipment **MUST** be attached and show:

   A. Name of patient and date of birth
   B. Date of service and charge for each
   C. Type of services/supplies/equipment received (surgery, office calls, crutches, etc.)
   D. Description of illness or accident
   E. Date of accident

3. Bills for prescription medication must include above information as well as:

   A. Patient's Name
   B. Description of Illness or Accident
   C. Name of Drug
   D. Name of Drug Store
   E. Prescribing Physician
   F. Date Purchased and Charge for Each Drug
   G. If actual drug receipt is not available, pharmacist signature is required

3. Questions on filing medical claims should be directed to:

   Customer Service Center
   Blue Cross Blue Shield of Wyoming
   P. O. Box 2266
   Cheyenne, WY 82003-2266
   307.634.1393
   1.800.442.2376 (in Wyoming)

NOTE: Balance due statements, cash register receipts, cancelled checks and cash receipts are **not** acceptable.

ITEMIZED BILLS CANNOT BE RETURNED

SAMPLE OF BCBS IDENTIFICATION CARD

DOE JOHN F	(subscriber name)	
ZSA 000000000	(BCBS-card number)	
XXXXX	960	460