



SUBSCRIBER MEDICAL CLAIM FORM

IMPORTANT: PLEASE READ THE INSTRUCTIONS ON THE BACK OF THIS FORM. Your Physician does not need to sign this form. Please complete and sign a separate form for each patient.

PATIENT INFORMATION

1. Patient's Name (No nicknames please) 4. Subscriber Identification Number as Shown on I.D. Card 2. Subscriber Name as Shown on I.D. Card 5. Group Number 6. Type Contract 3. Patient's Date of Birth 7. Patient's Sex 8. Patient's Relationship to Subscriber 9. Current Mailing Address

OTHER HEALTH INSURANCE INFORMATION

10. Is patient covered under any other health insurance plan? 11. Is patient covered under Medicare Part A (hospital) or Medicare Part B (medical)? Is subscriber still actively employed?

CONDITION AND TREATMENT

12. Was condition related to: Employment Auto Accident Other Accident / Injury Illness 13. If Accident / Injury, give date. 14. Describe the nature of accident or illness and list symptoms.

AUTHORIZATION

I certify that the information I have given is accurate to the best of my knowledge and that I, as the Subscriber, am claiming benefits only for the charges incurred by the patient identified above. I authorize the release of any medical information necessary to process this claim. Subscriber's Signature Date

WHEN SHOULD YOU USE THIS FORM?

This form is designed to help you, our Subscriber, file itemized medical bills for you or an enrolled family member. You should not submit this form if your Health Care Provider has filed a claim for you. Retain your receipt for your records.

If your benefit program includes the Key Physician Network and services are rendered by a Key Physician or other Participating Provider, these providers will file claims for you. **Please do not file claims for the services of a Key Physician or a Participating Provider – even if you have paid the services in full, and even if the Key Physician or Participating Provider gave you a receipt.** (Refer to your Provider Network Directory for a list of Participating Providers when you need health care services.)

PLEASE REVIEW YOUR MEDICAL BILLS AND FILE CLAIMS AT LEAST ONCE A MONTH TO ENSURE THE TIMELY PROCESSING OF YOUR CLAIMS.

CLAIMS FILING INSTRUCTIONS

1 Gather All Your **Itemized Medical Bills**

2 Separate Your Bills For Each Family Member

3 Complete a Separate Claim Form For Each Family Member

- Attach Itemized Medical Bills for the patient named on the form. Each itemized bill must include the patient's name; the health care provider's name and address; the date of each service; descriptions and charge for each service.
- If you are covered under any other health insurance or under Medicare Part B (medical), you must attach a copy of the Explanation of Benefits indicating their payment.
- Please use the Subscriber Prescription Drug Form to file any prescription drugs.

DID YOU

**** USE A SEPARATE CLAIM FORM FOR EACH FAMILY MEMBER?

**** COMPLETE EACH SECTION OF THE CLAIM FORM ENTIRELY?

**** COPY YOUR IDENTIFICATION NUMBER DIRECTLY FROM YOUR ID CARD?

**** ATTACH THE ORIGINAL ITEMIZED BILL(S) FROM THE PROVIDER THAT DESCRIBES ALL SERVICES RENDERED AND INCLUDES DATES OF SERVICE AND CHARGES?

**** KEEP A COPY FOR YOUR RECORDS?

Please forward your completed form to:

**Blue Cross & Blue Shield of Mississippi
P.O. Box 1043
Jackson, Mississippi 39215-1043**

For further information or additional copies of this form, please contact our Customer Service Department at (601) 932-3704.



**BlueCross BlueShield
of Mississippi**

Blue Cross & Blue Shield of Mississippi, A Mutual Insurance Company,
is an independent licensee of the Blue Cross and Blue Shield Association.