Medicare Advantage Subscriber Medical Claim Form

MASSACHUSETTS

Instructions
• **Submit a claim only when you are billed for services from a provider that does not directly submit a claim to the local Blue Cross Blue Shield plan.** • **Use reverse side or another sheet of paper to include any additional information if necessary.** • **Please include proof of payment and itemized bill from provider.** • **Keep a copy of all bills and claim forms submitted (originals will not be returned)** • **Any member liability such as copay, coinsurance, or deductible may apply.**

Subscriber Information		
Last Name:	First Name:	Middle Initial:
Cardholder Identification Number: (including prefix)	Date of Birth: (MM/DD/YY)	
Address:	Phone Number:	

Provider and Service Information	
Name of Provider:	Dates of Service (s):
Phone Number and Address of Provider:	Provider NPI Number:
In what setting did you receive treatment? (Examples: office, emergency room, hospital, clinic, etc.)	
What was your reason for seeking treatment? (Examples: asthma, diabetes, chest pains, etc.)	
Total charges for all services: $_____	Amount of reimbursement you are requesting: $_____
Describe the items or services that were received. (Examples: emergency room visit, flu shot, eyewear, durable medical equipment, hearing aid, etc.)	
Was treatment for: Accident at work? ☐Yes ☐No Date of accident ____/____/_____ Auto accident? ☐Yes ☐No Date of accident ____/____/_____ If yes, name of auto insurance:_____ Policy Number:_____ Other accident? ☐Yes ☐No Date of accident ____/____/_____	

Please complete the additional questions if services were performed outside of the USA:	
In what country were services performed?	***Itemized bills, receipts, and statements must be translated to English.*** If you need assistance with translating your documents, please contact your local town hall or library. You can also contact Member Services at 1-800-200-4255 (TTY 711) to help assist you with locating a Translation Center.
In what language was the bill/receipt written?	
In what currency was the bill paid?	

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Check which of the following acceptable proof of payment you are attaching to this form:

- ☐ A copy of the front and back of the cancelled check written to the provider.
- ☐ A credit card statement or receipt with itemized bill.
- ☐ A statement from the provider, on the provider's letterhead.

Please read this important information.

- When submitting claims for **PART D PRESCRIPTION DRUGS**, please use the Prescription Drug Claim form located on our website at www.bluecrossma.com/medicare-options
- If services were provided for **VACCINES**, please use the Vaccine Claim form located on our website at www.bluecrossma.com/medicare-options
- To ask for a **PART D COVERAGE DETERMINATION**, please use the Medicare Prescription Drug Coverage Determination form located on our website at www.bluecrossma.com/medicare-options

Signature is Required:

Member Signature: _____ Date:_____

Reimbursement of submitted claims is subject to your health plan and not guaranteed. Reimbursement will be according to the parameters of your health plan. It will be only for the amount your program would have paid on your behalf. The amount of reimbursement may be significantly lower than the original amount you paid.

Mail completed form and documents to: Blue Cross Blue Shield of Massachusetts, Medicare Advantage Claims, P.O. Box 55007, Boston, MA 02205

Questions:

If you have any questions, please call us at 1-800-200-4255, 8:00 a.m. to 8:00 p.m. Eastern Time, seven days a week except April 1 through September 30 when we are open Monday through Friday. TTY users should call 711.

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