MEMBER CLAIM FORM

This form must be completed for all Blue Cross of Idaho member submitted claims. A receipt of payment may be requested before the claim is processed. To eliminate any delays, please attach a copy of the receipt.

1. If any of the services were related to an accident, the ACCIDENTAL INJURY INFORMATION section below must also be completed. Failure to do so could result in delayed processing of your claim.
2. Circle the charges on your provider's statement that you are submitting and staple the statement to the form. The provider's statement must indicate: the individual provider's name or NPI number, a procedure code and diagnosis code for each service provided, the date the service was furnished, and the charge for each service. Submit a separate member claim form for each different provider.
3. To file charges for more than one patient, even if the charges are all on one bill, please:
   a. Complete a separate form for each patient AND attach a separate copy of the provider's bill to each patient's form, if needed.
   b. If a claim is submitted for services rendered by an out-of-state provider, we may forward your claim to the appropriate Blue Cross Blue Shield Plan to be processed.
4. Mail all forms to the mailing address at the bottom of this form.
5. For prescription drug claims, the pharmacy receipt must include the NDC number, name of drug, quantity and dosage. For members with a Pharmacy Benefits Manager (PBM), such as Blue Cross of Idaho Rx, pharmacy reimbursement may need to be sent to PBM directly. Additional information about your PBM may be found on the back of your membership ID card.

You should hear from us within 30 days upon receipt by our Plan. Do not re-submit these charges to us in the meantime.

PATIENT AND ENROLLEE INFORMATION

Patient's Name *(First Name, Middle Initial, Last Name)*

Patient's Date of Birth

Enrollee's Name *(First Name, Middle Initial, Last Name)*

Do you or any of your dependents have other health coverage? *(This includes other Blue Cross and Blue Shield coverage as well as Medicare.)*
☐ YES ☐ NO
Type of Coverage ☐ Medical ☐ Dental ☐ Vision
If Medicare ☐ Part A ☐ Part B ☐ Part D

Patient's Sex
☐ Male ☐ Female

Patient's Relationship to Enrollee
☐ Self ☐ Spouse
☐ Child ☐ Other

Enrollee's Blue Cross of Idaho Identification Number *(with Alpha Prefix)*

Coverage is for *(Check all applicable boxes)*
☐ Enrollee ☐ Spouse ☐ Children

Enrollee Group No./Name *(or Program Number)*

Name and Address of Other Carrier

ID Number with Other Carrier

Enrollee's Address *(Street, City, State, Zip Code)*

COVID-RELATED CLAIM *(Write QR code or print and include with your receipt)*

Is this claim for over-the-counter COVID-19 test(s)? ☐ YES ☐ NO **If yes, how many individual tests?** _____

Was this test purchased for employment purposes? ☐ YES ☐ NO

Were the COVID tests purchased for Blue Cross of Idaho-covered members in your own household? ☐ YES ☐ NO

Can you attest that the test(s) has not been (and will not be) reimbursed by another source? ☐ YES ☐ NO

ACCIDENTAL INJURY INFORMATION

(If not related to an accident or injury, please skip this section and sign at the bottom of the document)

Date of Injury *(mm/dd/yy)*

Describe how and where the injury occurred.

To your knowledge, who was responsible for the accident?

Have you received settlement from the responsible party?
☐ YES ☐ NO

Do you intend to make a claim against the responsible party?
☐ YES ☐ NO ☐ POSSIBLY

Is an attorney representing you in this matter? If so, please give your attorney's name and address. *(Blue Cross of Idaho may be contacting your attorney)*

Is the patient covered by Workers' Compensation or by a liability coverage other than Workers' Compensation for work-incurred injuries?
☐ YES ☐ NO

Was this injury or illness sustained while performing work required by the patient's employment?
☐ YES ☐ NO (If your claim is work-related and you have received a denial, please attach a copy.)

Has the patient filed a claim with the Industrial Accident Commission?
☐ YES ☐ NO

Was the condition the result of an auto accident?
☐ YES ☐ NO

Is the patient self-employed?
☐ YES ☐ NO

Has the patient notified their employer of this condition?
☐ YES ☐ NO

Has the patient filed a claim with their employer's liability coverage?
☐ YES ☐ NO

Signature of Enrollee

Make Payment to
☐ Enrollee *(Attach proof of payment)*
☐ Provider

Date Submitted

WARNING: *Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information, is guilty of a felony. In cases of proven fraud, Blue Cross of Idaho will terminate agreements for services and benefits, seek restitution of dollars lost, and pursue criminal prosecution to the full extent of the law.*

Street Address: 3000 E. Pine, Meridian, ID 83642-5995 • *Mailing Address:* P.O. Box 7408, Boise, ID 83707-1408 • 208-345-4550