



SUBSCRIBER CLAIMS SUBMITTAL FORM

IDENTIFICATION NUMBER	GROUP NUMBER	
SUBSCRIBER'S LAST NAME	FIRST NAME	INIT

CLAIMS SHOULD BE SENT TO:
 BLUE CROSS BLUE SHIELD OF MINNESOTA
 P.O. BOX 64668
 ST. PAUL, MN 55164
 (651) 662-4593 or (866) 477-1587

PATIENT'S LAST NAME	FIRST NAME	INIT	PATIENT'S BIRTHDATE
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PATIENT'S SEX	PATIENT'S RELATIONSHIP TO SUBSCRIBER		
_____ MALE _____ FEMALE	_____ SELF	_____ SPOUSE	_____ DEPENDENT

SUBSCRIBER'S ADDRESS: STREET	CITY	STATE	ZIP CODE
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SYMPTOMS AND/OR DIAGNOSIS:

Name of doctor or other health care professional providing service:

 Address:

The information given above is true and correct to the best of my knowledge:

Signature _____ Date Signed _____

Telephone Number – Home: (_____) _____ Office: (_____) _____

NOTE: Please refer to the back of this form for instructions on how to submit your claim.

IMPORTANT: PLEASE READ THE FOLLOWING INFORMATION – Claims must be submitted within 15 months of service date.

HOW TO SUBMIT YOUR CLAIM:

1. Complete a separate Subscriber Claim Form for each patient and for each doctor or other medical provider. Please answer all questions to get the fastest claims service.
2. Attach a copy of the itemized bill from the doctor's office. The bill should show: the diagnosis or symptoms of illness, the date, place and type of service, and the charge for each service.
3. For Medicare patients only: In addition to your itemized bill, attach a copy of your Explanation of Medicare Benefits Form.

NOTE: We cannot return your claim or materials you send with it. Please make copies for your personal files.