



**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		
<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> 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 – To meet timely filing requirements, submit your claims as soon as possible. All claims must be submitted within the timeframe indicated in your benefit book.

**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.