



**BlueCross BlueShield**  
of Western New York

PO Box 80  
Buffalo, NY 14240-2657  
1-888-995-3095

**SUBSCRIBER CLAIM FORM**

\*\*\*Mail completed form together with all itemized bills to address shown above.

If claim form is not complete or if any of the itemized bills require further information, such material may be returned to you with additional instructions.

**Otherwise all itemized bills will be retained by us and cannot be returned.**

**ALL QUESTIONS MUST BE ANSWERED. PLEASE PRINT OR TYPE.**

Enter names as shown on your BlueCross BlueShield Identification Card					
Subscriber Last Name	First Name	Initial	BlueCross BlueShield ID Number	Group Number	
Address-Number and Street	Please Check Here if this is a New Address <input type="checkbox"/>	City		State	ZIP Code

Patient Last Name	First Name	Initial	Date of Birth Month Day Year	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Patient's Relationship to Subscriber <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child
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<b>Other Health Insurance Coverage:</b> Does Patient have additional health insurance coverage through employer or other group health insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No <b>If yes, please complete.</b>		
Name of Other Policy Holder	Policy or Identification Number	
Policy Effective Date	Type of Coverage <input type="checkbox"/> Single <input type="checkbox"/> Family	Other Policy Holder's Birth Date
Name and Address of Other Insurance Carrier		

<b>Medicare Coverage:</b> Is the Patient entitled to Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No <b>If yes, please complete.</b>		
Patient's Medicare Identification Number _____		
Medicare Part A (Hospital Insurance)	Effective Date _____	
Medicare Part B (Medical Insurance)	Effective Date _____	
Is the Patient employed?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Is the Spouse employed? <input type="checkbox"/> Yes <input type="checkbox"/> No

<b>Were Expenses Due to an Accidental Injury:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>If yes, please complete.</b>		
Type of Accident:	<input type="checkbox"/> Work <input type="checkbox"/> Auto <input type="checkbox"/> Motorcycle <input type="checkbox"/> Other	Date of Accident _____

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Itemized Bills for **Service or Supplies must be attached to this form** with the following information indicated:

- Patient's Full Name.
- Amount charged for each service or supply.
- Date each service or supply was rendered.
- Description of each service or supply.
- Diagnosis or nature of illness for each service.
- Name and address of provider/supplier.
- Drug/Medicine bills must contain prescription number and name of prescribing physician.

**NOTE:**Cancelled checks or cash register tapes are not acceptable.

**In addition:** If you have received any payment or rejection notices from BlueCross BlueShield or Medicare for those expenses being reported, please attach them.

**IMPORTANT NOTICE**

"Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed Five Thousand Dollars and the stated value of the claim for each such violation."

Subscriber's Signature

Date

Home Phone Number:

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