Excellus

165 Court Street
Rochester, NY 14647

A nonprofit independent licensee of the
BlueCross BlueShield Association

[redacted]

Subscriber Claim Form

Mail Completed Claims To: **Excellus BlueCross BlueShield**
PO Box 22999
Rochester, NY 14692

Subscriber identification number (including ID prefix):

Subscriber's Full Name

Address

City, State, Zip Code

If your address has changed or is incorrect, please call our Customer Service Department as instructed on the back of the form.

1. Patient Information:

Patient's full name:

Sex: ☐ Male ☐ Female

Relationship to subscriber: ☐ 1. Self ☐ 3. Child ☐ 2. Spouse ☐ 4. College Student

Patient's date of birth:

If treatment was the result of a non-work injury, give date of injury:

If other than USA, in what country was patient treated?

Patient diagnosis *(illness/injury which required treatment):*

2. Check if you want payment to be made directly to the provider . . . ☐
(Nonparticipating providers are not eligible.)

3. Medicare:

Regardless of age, if the patient is covered by Medicare, please be sure to send bills and matching "Explanation of Medicare Benefit".

4. Motor Vehicle or Work Related Illness or Injury:

a. Was the treatment in any way motor vehicle related? . . . . . ☐ YES ☐ NO

b. Was the treatment the result of a work related illness or injury? . . . . . ☐ YES ☐ NO

c. If answer to a. or b. is yes, please describe accident or illness:

Date of accident or illness:

Check If: ☐ **I have other Insurance.**
☐ **My other Insurance has changed.**

5. Other Insurance Carrier:

If the patient is covered by another health care plan:

If we are your secondary insurance, please be sure to send itemized bill and matching Explanation of Benefit form(s) from the other insurance company.

Policyholder's name:	Date of birth:	Social Security number:	Relationship to patient:
Name of policyholder's employer:			Employment status: ☐ Active ☐ Retired
Name and address of insurance carrier:			This policy covers the: ☐ Individual ☐ Husband & Wife ☐ Family ☐ Parent & Child
Policy or certificate number:	Effective/Cancellation date:	Carrier's telephone number:	Spouse's date of birth:

6. Claim Date and Subscriber Signature: *(Unsigned claims will be returned.)*

Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information, or conceals information concerning any fact material thereto, for the purpose of misleading, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed $5,000 and the stated value of the claim for each violation. In addition, I hereby authorize any insurance company, organization, employer, hospital, doctor or any other provider of service to release any information requested relevant to this claim and any attached bills.

Date: Subscriber's signature:

How To Submit Your Claim

This claim form can be used to submit all your bills. However, a separate claim form must be completed for each person's bills.

If you need additional claim forms, have any questions about completing the claim form or benefits covered under your contract, please contact us at the number listed on your identification card.

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In order to process your claim promptly, please refer to the following guidelines to ensure that all necessary information is included:

A. Submit bills for each patient on separate claim forms. A separate claim form is also required for different calendar years. Please submit the original bills with your claim form. Keep copies for your own records. The actual bills are necessary for claims processing.

B. Bills must include:

Name and address (on letterhead) of the provider of service or supply (hospital, doctor, pharmacy, etc.).

Patient's full name.

Type of service or supply (office visits, chest x-ray, etc.).

Place of service (inpatient or outpatient hospital, office, etc.).

Date and charge for each service or supply provided.

Patient's diagnosis (the medical condition for which the patient was treated).

C. Bills for the following services should also include:

FOR THOSE CONTRACTS WITH PRESCRIPTION DRUG COVERAGE - Prescription number, name of drug, and name of prescribing doctor is required.

Private Duty Nurse - The type of Nurse (RN or LPN), license number, the shift and hours worked and a statement of medical necessity from the prescribing doctor.

Durable Medical Equipment (wheelchair, oxygen tank, etc.) - A statement of medical necessity from the prescribing doctor which indicates how long the equipment will be used and a statement from the equipment supplier showing both the rental and purchase price.

D. Cash register receipts, canceled checks, money orders, credit card vouchers and personal lists of services or bills stating only 'balance forward' are not acceptable as substitutes for bills.

Our employees are dedicated to prompt and accurate claim payments to our subscribers. By following these instructions and filling out the claim form completely, you will help us meet our goal of processing your claim in a satisfactory manner.