



Regence BlueShield

An Independent Licensee of the Blue Cross and Blue Shield Association

DIRECT MEMBER REIMBURSEMENT FORM

Thank you for choosing us for your health insurance coverage. Use this claim form for any reimbursement requests you may have. If you received services from a participating provider, your claim should be submitted by the provider; therefore, you do not need to submit this form unless you know that your claim was not submitted. Please complete a separate form for each family member, pharmacy or provider (print additional copies of Pg. 2 if necessary). **For claim filing time limits, review your benefit information.**

1. Complete the information below and where indicated on the following page.
2. Write your ID number on the top of each page.
3. Tape your original receipts in the boxes marked for receipts; cash register receipts will not be accepted.
4. Retain copies of receipts for your records. Receipts will not be returned.
5. Sign the completed form where indicated at the bottom of this page, and mail to:

Regence BlueShield
P.O. Box 21267
Seattle, WA 98111-3267

MEMBER INFORMATION

Patient's Name (Last, First, M.I.)			Patient's Date of Birth		Patient's Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	
Policyholder's Name (Last, First, M.I.)			Patient's Relationship to Policyholder <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent			
Policyholder's Address (Street, City, State & Zip)					Telephone Number	
Patient's ID Number (3 letters followed by 9 numbers)		Group Name			Group Number	

OTHER INSURANCE INFORMATION

Are you or ANY family member on this policy covered by other

Medical coverage? <input type="checkbox"/> YES <input type="checkbox"/> NO	Vision coverage? <input type="checkbox"/> YES <input type="checkbox"/> NO
Dental coverage? <input type="checkbox"/> YES <input type="checkbox"/> NO	With Orthodontia? <input type="checkbox"/> YES <input type="checkbox"/> NO
Prescription coverage? <input type="checkbox"/> YES <input type="checkbox"/> NO	

If YES: Group Individual

Are you or any family members covered by Medicare? YES NO If YES: Part A Part B Part D

IF THE ANSWER TO ANY OF THE ABOVE QUESTIONS IS "YES", please complete this section regarding the other insurance. If there are more than 1 additional policy, attach the requested information for each policy on a separate sheet of paper.

Name of Other Insurance	Subscriber's Name, ID# & Birth Date	Subscriber's Relationship to Regence Policyholder
Address for Submitting Claims		
This Other Insurance Covers: <input type="checkbox"/> Regence Policyholder's Spouse <input type="checkbox"/> Regence Policyholder <input type="checkbox"/> Dependents		If covered children are from divorced parents, indicate name of person with legal custody:
Name of Subscriber's Employer	<input type="checkbox"/> Active <input type="checkbox"/> Retiree	Effective date of this plan

Please indicate why the patient paid cash _____

I certify that the above statements are correct and hereby authorize any physician, hospital, employer, union, insurance company, or prepayment organization to supply my employer and its agents any information required in connection with this claim. A photocopy of this authorization shall be as valid as the original.

Signed (Subscriber or Patient) _____

Date _____

Prescription (RX) receipts must contain:

- RX number,
- Date RX was filled,
- Provider's name,
- Drug name and NDC#,
- Quantity and days supply,
- Charge

Medical, Dental & Vision receipts must contain:

- Provider's name and address,
- Diagnosis and procedure codes,
- Itemized charges

Contact the provider or pharmacy if you need additional information

TAPE RECEIPT HERE
In date order

Nature of Illness or Injury

Doctor's Name (if not on receipt)

If Injury, Date Occurred

How, When, Where

TAPE RECEIPT HERE
In date order

Nature of Illness or Injury

Doctor's Name (if not on receipt)

If Injury, Date Occurred

How, When, Where