



Community Blue • Traditional Blue

A Division of HealthNow New York Inc. An Independent Licensee of the BlueCross BlueShield Association

P.O. Box 80
Buffalo, NY 14240-0080



MEDICAL BENEFITS 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 BLUESHIELD IDENTIFICATION CARD.

1	SUBSCRIBER'S LAST NAME	FIRST NAME	INITIAL	BLUESHIELD ID. NO.	GROUP NUMBER
	ADDRESS-NUMBER AND STREET	Please Check Here If This Is A New Address <input type="checkbox"/>	CITY	STATE	ZIP CODE

2	PATIENT'S LAST NAME	FIRST NAME	INITIAL	DATE OF BIRTH	SEX	PATIENT'S RELATIONSHIP TO SUBSCRIBER
				MONTH DAY YEAR	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	<input type="checkbox"/> SELF <input type="checkbox"/> CHILD <input type="checkbox"/> SPOUSE

3	OTHER HEALTH INSURANCE COVERAGE:				
	DOES PATIENT HAVE ADDITIONAL HEALTH INSURANCE COVERAGE THROUGH EMPLOYER OR OTHER GROUP HEALTH INSURANCE? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, PLEASE COMPLETE.				
	NAME OF OTHER POLICY HOLDER			POLICY OR IDENTIFICATION NUMBER	
	POLICY EFFECTIVE DATE	TYPE OF COVERAGE		OTHER POLICY HOLDER'S BIRTH DATE	
		<input type="checkbox"/> SINGLE <input type="checkbox"/> FAMILY			
NAME AND ADDRESS OF OTHER INSURANCE CARRIER					

4	MEDICARE COVERAGE: IS THE PATIENT ENTITLED TO MEDICARE? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, PLEASE COMPLETE.				
	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

5	WERE EXPENSES DUE TO AN ACCIDENTAL INJURY: <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, PLEASE COMPLETE.				
	TYPE OF ACCIDENT:	<input type="checkbox"/> WORK	<input type="checkbox"/> AUTO	<input type="checkbox"/> MOTORCYCLE	<input type="checkbox"/> OTHER

SUBSCRIBER'S SIGNATURE AND ITEMIZATION OF BILLS REQUIRED ON THE OTHER SIDE.



