of Tennessee
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BlueCross BlueShield of Tennessee Claims
Service Center
1 Cameron Hill Circle, Suite 0002
Chattanooga, Tennessee 37402-0002

Subscriber Health Care Claim Form

- Confidential -

Complete a separate claim form for each patient. Please print.

Subscriber Information - *Complete for all claims.*

Subscriber Name:

Last _____ First _____ MI ____

Subscriber Identification Number: _____ *(from your card)*

Address:

Street _____

City _____ State _____ ZIP Code _____

Telephone Number: Work: (_____) _____ Home: (_____) _____

Patient Information - *Complete for all Claims - All statements must be completed.*

Patient Name:

Last _____ First _____ MI ____

Patient Date of Birth: ____ / ____ / _____ (MM / DD / YYYY)

Is patient eligible for Medicare? ❑ No ❑ Yes

Is patient covered under any other group health insurance plan except Medicare? ❑ No ❑ Yes

Give name, address and policy number of other health insurance company. See instructions on back.

Name of Insurance Company _____

Policy Number _____

City _____ State _____

Accident Information - *Complete only if claim is due to an accident.*

Place of Accident:

City _____ State _____

Date of Accident: ____ / ____ / _____ (MM / DD / YYYY)

Accident was:

❑ Job Related ❑ Motor Vehicle Related

❑ Other - *Briefly Explain*: _____

Provider Information - *Complete for all claims.*

Provider Name: Last _____ First _____

Provider Address: Street _____ City _____ State _____ Zip Code _____

Provider Tax ID: _____

Provider NPI: _____

Provider Specialty: _____

Provider Phone: _____
(Including area code)

continued on back

Claim Information - *Complete for all claims.*

- Care received in a: ❑ Office ❑ Hospital ❑ Clinic ❑ Urgent Care ❑ Other
- Date of care: _____
- Care provided: Ask your provider for a list of the numerical procedure codes we use to process a claim, along with the charge for each service.
  - Charges: Please itemize each charge. Don't send multiple services with only one total.
- Reason for visit: Ask your provider for your diagnosis code, or just describe why you got care:

Please include a copy of receipts and or "superbill" (you can ask your provider for this). If you can't get a superbill, please include a full description of the care provided and reason for visit.

Authorization - *Complete for all claims.*

Pay benefits for this claim: ❑ To me, the subscriber (proof of payment required).

❑ Directly to the provider of service *(hospital, physician, skilled nursing facility, etc.).*

1. *I hereby authorize any hospital, insurance company, or any other provider of services to release any information requested with respect to this claim and attached bills.*
2. *I certify that the information on this claim and the attached bills is complete and true.*
3. *I understand it is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.*

_____ _____

Signature *Date*

Instructions for Filing Claims

Please use the following procedure if your provider doesn't file a claim. This information applies to physician, hospital, dental, prescription and vision claims. Note: Providers in our networks are required to file claims for you.

1. Fill out all the basic information on the front page of the form. If you get a claim form from your provider, it may or may not ask for all this information. If it doesn't, please include this information in a separate document to help us process the claim.
2. Attach all itemized bills related to this claim to this form. The provider or facility where you got care should provide you with these bills. The itemized bills should include:
   - The name and address of the provider;
   - The patient's name;
   - The date of care;
   - The procedure code for each service (your provider can supply these codes)
   - The charge for each service (canceled checks, cash register receipts, money orders, credit card vouchers, personal list of services or bills only stating "balance forward" are not acceptable substitutes for itemized bills).

Note: Please keep copies of all information you send us for your records.

3. Mail the completed claim form and attachments to:

BlueCross BlueShield of Tennessee
Claims Service Center
1 Cameron Hill Circle, Suite 0002
Chattanooga, Tennessee 37402-0002

After your claim is processed, we'll send you an Explanation of Benefits and a check (if we owe you money).