



**BlueCross BlueShield**  
of Western New York

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 BLUECROSS BLUESHIELD IDENTIFICATION CARD.

**1**

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

**2**

<b>PATIENT'S LAST NAME</b>	<b>FIRST NAME</b>	<b>INITIAL</b>	<b>DATE OF BIRTH</b> MONTH DAY YEAR	<b>SEX</b> <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	<b>PATIENT'S RELATIONSHIP TO SUBSCRIBER</b> <input type="checkbox"/> SELF <input type="checkbox"/> CHILD <input type="checkbox"/> SPOUSE
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**3**

**OTHER HEALTH INSURANCE COVERAGE:**

DOES PATIENT HAVE ADDITIONAL HEALTH INSURANCE COVERAGE THROUGH EMPLOYER OR OTHER GROUP HEALTH INSURANCE?  YES  NO **IF YES, PLEASE COMPLETE.**

<b>NAME OF OTHER POLICY HOLDER</b>	<b>POLICY OR IDENTIFICATION NUMBER</b>
<b>POLICY EFFECTIVE DATE</b>	<b>TYPE OF COVERAGE</b> <input type="checkbox"/> SINGLE <input type="checkbox"/> FAMILY
<b>OTHER POLICY HOLDER'S BIRTH DATE</b>	
<b>NAME AND ADDRESS OF OTHER INSURANCE CARRIER</b> Fold	

**4**

**MEDICARE COVERAGE:** IS THE PATIENT ENTITLED TO MEDICARE?  YES  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?  YES  NO      IS THE SPOUSE EMPLOYED?  YES  NO

**5**

**WERE EXPENSES DUE TO AN ACCIDENTAL INJURY:**  YES  NO **IF YES, PLEASE COMPLETE.**

TYPE OF ACCIDENT:  WORK  AUTO  MOTORCYCLE  OTHER      DATE OF ACCIDENT \_\_\_\_\_

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

