BlueCross BlueShield of Nebraska

An Independent Licensee of the Blue Cross and Blue Shield Association

P.O. Box 3248 • Omaha, NE 68180-0001

BLUE CROSS AND BLUE SHIELD OFFICE USE ONLY

SUBSCRIBER'S CLAIM FORM

NON-PARTICIPATING PROVIDER

Please type or print clearly.
Check with the physician to verify the charges have not been submitted.
One claim form per patient per provider.
See reverse side for instructions.

SUBSCRIBER INFORMATION

1. Blue Cross and Blue Shield I.D. Number:

(ALPHA PREFIX) (NUMBERS)

2. Subscriber's Home Phone Number:

(AREA CODE) (TELEPHONE NUMBER)

3. Subscriber's Name:

(LAST NAME) (FIRST NAME) M.I.

4. Subscriber's Address:

Street:

City: State: Zip:

5. Subscriber's Employer:

PATIENT INFORMATION

6. Patient's Name:

(LAST NAME) (FIRST NAME) M.I.

7. Patient's Relationship to Insured:
❒ Self ❒ Spouse ❒ Child ❒ Other

8. Sex:
❒ Male ❒ Female

9. Date of Birth:
M M D D Y Y

(Complete for dependent child over age 19)

10. Is patient a full time student? ❒ Yes ❒ No **11.** If Yes, what school? _____

12. Number of credit hours taken at time of care? _____ **13.** Undergraduate ❒ **14.** Graduate ❒

SERVICE INFORMATION

Service related to:
15. Employment? ❒ Yes ❒ No **16.** Auto accident? ❒ Yes ❒ No If Yes, date of accident:
M M D D Y Y

17. Other accident type? ❒ Yes ❒ No
18. Diagnosis or description of illness or injury requiring treatment:

19. Date illness began:
M M D D Y Y

Total of charges submitted:
DOLLARS CENTS

20. Name and address of the attending practitioner:

I certify the above is complete and correct and that I am claiming benefits for charges incurred by the above named patient.

Subscriber signature _____ Date _____

NOTE: A separate claim form must be completed for each patient and each provider (prescription drugs from multiple providers can be on the same claim for the same patient). All information sections **must** be completed. Please check with your provider of care to see if he or she has already filed any of these charges for you.

SUBSCRIBER INFORMATION

1. Identification number: Enter the identification number and any alpha prefix as shown on your Blue Cross and Blue Shield card. (If you are age 65 or older, this number may not be the same as your Medicare number.)
2. Subscriber's home phone number: The area code and phone number.
3. Subscriber's name: Enter the subscriber's name as shown on your identification card.
4. Subscriber's address: The home address of the subscriber.
5. Subscriber's employer: The employer name of the subscriber.

PATIENT INFORMATION

6. Patient's name: The patient's full legal name (not nickname) and "Jr." or "Sr." If applicable.
7. Patient's relationship to subscriber: Check the appropriate box to indicate the relationship of the patient to the subscriber.
8. Sex: The sex of the patient.
9. Date of birth: The date of birth of the patient. Provide month, day and year.
10. Is the patient a full time student? If the patient is a dependent child, 19 years of age or older, complete the student information.
11. What school? Provide the full name of the school, college or university.
12. Number of credit hours taken at time of care? Provide the college credit hours that were being taken at the time of care.
13. Undergraduate: If the student has not earned a degree.
14. Graduate: If the student has earned a degree.

SERVICE INFORMATION

15. Service related to employment? (Yes - No) Was the care due to an accident/illness related to employment?
16. Service related to auto accident? (Yes - No) Was the care as the result of an auto accident?
17. Services related to other accident type? (Yes - No) Accident NOT due to auto or employment.
18. Diagnosis or description of illness or injury requiring treatment: Provide information regarding the diagnosis or description of the illness or injury.
19. Date illness began: Provide month, day and year that the illness began.
20. Name and address of the attending practitioner: Provide the name and address of the primary physician.