MASSACHUSETTS

# MANAGED BLUE FOR SENIORS MEDICAL CLAIM FORM

## INSTRUCTIONS

- Submit a claim only when you're billed for services from a provider that doesn't directly submit a claim to the local Blue Cross Blue Shield plan.
- Use reverse side or another sheet of paper to include any additional information if necessary.
- Please include proof of payment and itemized bill from provider.
- Keep a copy of all bills and claim forms submitted (originals won't be returned).
- Any member liability such as copay, co-insurance, or deductible may apply.
- For services rendered OUTSIDE OF THE U.S., visit **bcbsglobalcore.com**.

## SUBSCRIBER INFORMATION

Last Name: | First Name: | Middle Initial:

Cardholder Identification Number: (including prefix) | Date of Birth: (MM/DD/YY) | Phone Number:

Address: | Medicare Number:

## PROVIDER AND SERVICE INFORMATION

Name of Provider: | Dates of Service(s): (MM/DD/YY)

Phone Number and Address of Provider: | Provider NPI Number:

In what setting did you receive treatment? (Examples: office, emergency room, hospital, clinic, etc.)

Total charges for all services:
$

Amount of reimbursement you're requesting:
$

Describe the items or services that were received. (Examples: emergency room visit, flu shot, eyewear, durable medical equipment, hearing aid, etc.)

| | | | | |
|---|---|---|---|---|
| Was treatment for: | Accident at work? | ☐ Yes | ☐ No | Date of accident (MM/DD/YY) |
| | Auto accident? | ☐ Yes | ☐ No | Date of accident (MM/DD/YY) |
| | Other accident? | ☐ Yes | ☐ No | Date of accident (MM/DD/YY) |

**Review this checklist before sending your claim to us. Incomplete forms may be returned to you.**

- ☐ Have you listed your Managed Blue for Seniors Identification Number in the space provided?
- ☐ Have you attached all related Explanation of Benefits (EOB) or Health Plan Summary of Benefits forms you may have received previously for these services?
- ☐ Have you signed and dated the completed claim(s) form?
- ☐ Have you kept a copy of all receipts and EOBs?

## CERTIFICATION AND AUTHORIZATION

I authorize the release of any information to Blue Cross and Blue Shield about my examination and treatment. I certify that the information provided in the support of this claim is complete and correct and that I haven't been previously reimbursed for these services.

Member's Signature: Date: (MM/DD/YYYY)

### Mail completed form and documents to:

Blue Cross Blue Shield of Massachusetts,
P.O. Box 55007, Boston, MA 02205

Blue Cross Blue Shield of Massachusetts complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity.

ATTENTION: If you don't speak English, language assistance services, free of charge, are available to you. Call Member Service at the number on your ID card (TTY: **711**).

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia con el idioma. Llame al número de Servicio al Cliente que figura en su tarjeta de identificación (TTY: **711**).

ATENÇÃO: Se fala português, são-lhe disponibilizados gratuitamente serviços de assistência de idiomas. Telefone para os Serviços aos Membros, através do número no seu cartão ID (TTY: **711**).