BlueCross BlueShield of Vermont
An Independent Licensee of the Blue Cross and Blue Shield Association.

BERLIN
445 INDUSTRIAL LANE
BERLIN, VERMONT 05641

P.O. BOX 186
MONTPELIER
VT 05601-0186

800 247 2583
800 922 8778
800 255 4550

MEMBER CLAIM FORM – SUBMISSION INSTRUCTIONS

Read these submission instructions carefully and submit your completed form with all attachments. We offer several convenient ways to submit your claim:

Preferred Method – Member Resource Center

Log into our secure member portal online at www.bcbsvt.com/MRC to access your Secure Message Center!

- ✓ Click to send a "New Message"
- ✓ Click to "Add Recipient" and select the "Customer Service" department.
- ✓ Attach your claim form, invoice, and submission checklist and "Send."
- ✓ Receive a confirmation message within 24 hours of receipt.

Alternate Methods

Snail Mail	BlueCross BlueShield of VT P.O. Box 186 Montpelier, VT 05601-0186
Email	CustomerService@bcbsvt.com
Fax	(866) 764-9653

We will return all incomplete claims. Please note that in most instances we aren't allowed to contact out-of-state and/or out-of-network providers to collect missing information.

IMPORTANT INFORMATION

- Submit a separate claim form for each member of the family who had services.
- Submit a separate claim form for each provider you saw.
- If your claim is for prescription drugs purchased at a pharmacy, you must submit your claim on a Prescription Reimbursement/Drug Claim Form directly to your Plan's pharmacy benefits manager.
- Keep a copy of your completed claim form and the itemized invoice for your own records.

If you have another primary insurance plan, such as Medicare, and you are submitting your claim to BCBSVT to consider balances left after your primary insurance, you must submit a copy of the primary carrier's explanation of benefits or a denial/opt-out letter.

Blue Cross and Blue Shield of Vermont issues payments for member-payable claims to the health plan benefits subscriber.

TRACKING PROGRESS

To view the status of your claims, login to our secure Member Resource Center at bcbsvt.com/MRC. Please allow up to 10 business days after submission for your claim to appear online.

NEED HELP?

Use our Member Claim Form Submission Checklist to ensure that your claim is complete and ready for submission.

If you would like assistance filling out this checklist and understanding your benefit plan, contact our customer service team! We love to help our members get the most out of their benefit plans. Call us using the number on the back of your ID card or send us a secure message through our Member Resource Center!

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MEMBER CLAIM FORM

PATIENT INFORMATION

Patient's Name (Last, First)

Patient's Date of Birth
MO | DAY | YR

BCBSVT ID Number from ID card
Prefix (ex: ZID) | Number (ex: V812345678000)

Patient's Phone including area code
( )

Patient's Gender
☐ Female ☐ Male

Patient's Address
Street:
City:
State: Zip:

Health Plan Subscriber's Name (Last, First)

Patient's Relationship to Subscriber
☐ SELF ☐ SPOUSE
☐ CHILD ☐ OTHER

Health Plan Subscriber's Date of Birth
MO | DAY | YR

Health Plan Group Number

Is this an employer-based health plan?
☐ YES ☐ NO

PROVIDER INFORMATION

Provider and Practice/Facility Name

Provider's Phone including area code
( )

Ordering or Referring Provider and State Located
Name | State

Provider's Address
Street:
City:
State: Zip:

Provider's ID Numbers
NPI
Tax ID
License Number | State Issued

ADDITIONAL INFORMATION

Was the condition related to the patient's employment?
☐ YES ☐ NO
If yes, include date of injury:
MO | DAY | YR

Was the condition related to an accident or injury involving another party?
☐ YES ☐ NO
If yes, include date of accident or injury:
MO | DAY | YR

Other insurance company name and phone number
Name:
Phone including area code
( )

CLAIM INFORMATION (Please work with your provider to fill in the shaded areas.)

Date of service MO / DAY / YR	Description of Service	Procedure Code	Modifier	Diagnosis Code	Charge	Units	POS
					$		
					$		
					$		
					$		
					$		
					$		
				Total Bill:	$		

I authorize any hospital, physician or other provider to release to Blue Cross and Blue Shield of Vermont any information deemed necessary to process my claim for benefits. 1250.01: The person signing this form understands that the willful making of a false or fraudulent statement herein renders him/her liable to prosecution.

Signature of Member or Subscriber:_____ Date Signed:_____