MASSACHUSETTS

Claim for Reimbursement Affidavit

This form may be used by surviving spouses and next of kin to request reimbursements for claims related to a deceased Blue Cross Blue Shield health plan subscriber.

I, _____, **(PRINT YOUR NAME)** residing at

_____ **(STREET, CITY, STATE, ZIP CODE)** in the County of

_____ Commonwealth/State of _____

do solemnly affirm the following:

1. I am the surviving spouse, or next of kin and heir, of _____ **(SUBSCRIBER'S NAME)** named as a subscriber under a contract with Blue Cross Blue Shield of Massachusetts, policy ID number _____. **(ID NUMBER)**
2. I am submitting a claim on behalf of _____ **(SUBSCRIBER'S NAME)** who is now deceased. This claim is for reimbursement of services that are covered under the said contract by payment directly to the subscriber.
3. I have paid for these services (or the subscriber paid for them before their death) and have attached the bills and receipts for health care services.
4. The named subscriber died without assets to be probated, and without outstanding liabilities. As heir, I am entitled to the amount due on the policy identified above.
5. If I receive the entire amount due on the said claim, I will distribute it among other persons if they are legally entitled to it.
6. In consideration of payments to me on the said policy by Blue Cross Blue Shield of Massachusetts, I agree to indemnify and hold harmless Blue Cross Blue Shield of Massachusetts from any and all liability for doing so.

_____

(SIGNATURE OF PERSON SUBMITTING CLAIM)

Notary

Commonwealth/State of: _____

County of: _____

Before me on this day _____ **(DATE)** personally appeared

_____, **(CLAIMANT NAME)** and swore that the signature made was on his or her own free act and deed.

Notary Public: _____

My Commission Expires: _____

Please return this form to:

Blue Cross Blue Shield of Massachusetts
Member Service Correspondence
P.O. Box 9134
N. Quincy, MA 02171-9134