MASSACHUSETTS

VISION

SEE INSTRUCTIONS ON THE BACK OF THIS FORM.
PLEASE PRINT ALL INFORMATION CLEARLY.

DO NOT WRITE IN THIS SPACE
OFFICE USE ONLY

SUBSCRIBER INFORMATION

Identification Number	Subscriber's Last Name	First Name	Middle Initial

Address-Number and Street	City	State	Zip Code

Employer's Name

PATIENT INFORMATION (Use a separate form for each patient)

Patient's Last Name	First Name	Middle Initial	Date of Birth (Mo / Day / Year)

Sex
1. ☐ Male
2. ☐ Female

Patient Is: (Check one)
1. ☐ Subscriber (Contract holder)
2. ☐ Spouse (To contract holder)
3. ☐ Child (Age 18 or younger)
4. ☐ Handicapped Dependent (Age 19 or older)
5. ☐ Student (Age 19 or older)
6. ☐ Stepchild
7. ☐ Other (Specify) .....

PATIENT ENROLLED IN: (If yes, give identification number and effective date)

Medicare Part A (Hospital)? ☐ No ☐ Yes
Medicare Part B (Medical)? ☐ No ☐ Yes
Other Blue Cross and Blue Shield membership? ☐ No ☐ Yes
Other insurance plan? ☐ No ☐ Yes

Identification number: .....
Effective date: .....

Name and address of other insurance: .....

WAS TREATMENT FOR:

			MO	DAY	YR
1. Accident at work?	☐ No	☐ Yes Date of Accident:			
2. Auto accident?	☐ No	☐ Yes Date of Accident:			

If yes, give name of auto insurance: .....

Policy number: .....

CLAIM INFORMATION (Attach itemized bills to section noted below.)

ATTACH ORIGINAL BILLS HERE

TYPE OF SERVICE	PROVIDER NAME	DIAGNOSIS	Date of Service MO	DAY	YR	AMOUNT CHARGED	OFFICE USE ONLY

TOTAL NUMBER OF BILLS ATTACHED: _____ **TOTAL CHARGES: $** _____

CERTIFICATION AND AUTHORIZATION (This form must be signed and dated)

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 support of this claim is complete and correct and that I have not been previously reimbursed for these services.

Subscriber's Signature: ..... **Date:** .....

INSTRUCTIONS

File this form when you receive a bill for services for which the provider does not directly submit a claim to Blue Cross and Blue Shield of Massachusetts.

When filing a claim, please be sure to:

1. Complete a separate form for each patient.
2. Answer all questions on this form and complete claim checklist below.
3. Attach original itemized bills which include:

   Patient's name
   Date(s) of service
   Type(s) of service
   Individual charges for each date and type of service rendered
   Name and address of provider of service
   Diagnosis

Additionally, drug receipts must indicate:

   Prescription number(s)
   Name of drug
   Quantity dispensed
   Name of prescribing physician

4. Include only one service on each line.

NOTE: PLEASE KEEP COPIES OF YOUR BILLS PRIOR TO SENDING THE ORIGINALS WITH THIS CLAIM, SERVICES THAT ARE DENIED FOR PAYMENT WILL BE NOTED ON YOUR CLAIM SUMMARY. WE DO NOT RETURN ANY BILLS TO YOU EVEN IF THEY ARE DENIED FOR PAYMENT.

5. Attach all related Claim Summary or Explanation of Medicare Benefits forms you may have received previously on these services.

6. Sign and date the completed form.

7. MAIL THIS FORM TO:

NATIONAL CLAIMS DEPARTMENT
BLUE CROSS AND BLUE SHIELD OF MASSACHUSETTS
P.O. BOX 986030
BOSTON, MA 02298

CLAIM CHECKLIST

PLEASE REVIEW THIS CHECKLIST BEFORE SENDING YOUR CLAIM TO US. INCOMPLETE FORMS MAY BE RETURNED TO YOU.

- ☐ Have you listed your Blue Cross and Blue Shield identification number in the space provided?
- ☐ Have you listed a diagnosis or illness on each line of the claim information section?
- ☐ Have you listed the total charges for this claim?
- ☐ Have you attached original itemized bills?
- ☐ Have you attached all related Claim Summary or Explanation of Medicare Benefits forms you may have received previously on these services?
- ☐ Have you signed and dated the completed claim form?