



MEMBER APPLICATION FOR PAYMENT CONSIDERATION

Medical, Vision and Hearing Benefit

Fill out online, print, sign and mail with original receipts to:

BLUE CROSS BLUE SHIELD OF MICHIGAN
27000 WEST 11 MILE ROAD, M.C. B531
SOUTHFIELD, MI 48034-2200

THIS INFORMATION CAN BE TAKEN FROM YOUR BCBSM I.D. CARD



SUBSCRIBER'S ALPHA/NUMERIC CONTRACT NUMBER

Alpha

Numeric

MEMBER INFORMATION

SUBSCRIBER'S LAST NAME

SUBSCRIBER'S FIRST NAME

BCBSM GROUP NUMBER

SUBSCRIBER'S STREET ADDRESS

CITY

STATE

ZIP CODE

PATIENT INFORMATION

PATIENT'S FIRST NAME

SEX

MEDICARE HIB NUMBER

M

F

PATIENT'S DATE OF BIRTH

DATE OF INJ/ILL/LMP

ADMISSION DATE

DISCHARGE DATE

WAS THIS RELATED TO AN AUTO ACCIDENT? YES NO

WAS THIS WORK RELATED? YES NO

OTHER HEALTH INSURANCE? YES NO

NAME OF OTHER INSURANCE

POLICY NUMBER

I certify that the above information is true and the enclosed material is correct and unaltered and the expenses were incurred by the patient. I understand all material submitted becomes the property of Blue Cross Blue Shield of Michigan and will not be returned. I realize false receipt or fraudulent alterations of these materials will result in civil or criminal prosecution. I authorize the release of any information necessary to process or review this claim.

DATE

PHONE

Sign after printing

SUBSCRIBER'S SIGNATURE

To speed up our processing remember to:

- Separate claim forms are necessary for different patients. You will also need and use another claim form for each of the different programs (medical, dental, vision, hearing).
- Mail only original receipts including all pertinent information on provider's letterhead. Without this information your claim will be returned to you. Cash register receipts, cancelled checks, money orders, and personal itemizations cannot be used in benefit payment consideration.
- If the patient has Medicare coverage, fill in the Medicare number including alpha characters. Be sure you include the Medicare Summary Notice that was sent explaining the charges paid or not paid by Medicare. This is not required for dental, vision or hearing services.
- If the patient has other health insurance that has processed the service, be sure you include the Explanation of Benefit statement that was sent explaining the charges paid or not paid.
- Make copies of the original receipts for your files before submitting the original. All materials submitted will be retained for our files and cannot be returned to you.

YOUR RIGHT TO CONFIDENTIALITY: We will not release any information about you except: (1) When you ask us to in writing or (2) When release (to another insurance company for example) is necessary to process or review a claim. We will tell you which information we release to whom, if you request it.