



Member Claim Form

Street Address:
3000 E. Pine, Meridian, ID 83642-5995
Mailing Address:
P.O. Box 7408, Boise, ID 83707-1408
(208) 345-4550

This form must be filled out for all claims submitted by a member.

- If any of the services were related to an accident, you must also complete the **ACCIDENTAL INJURY INFORMATION** section below.
- Circle the charges on your provider's statement that you are submitting, and staple the statement to this form. The provider's statement must show, for each service: a procedure code and diagnosis code, the date it was furnished, and the charge for the service. You will need a separate member claim form for each different provider and for each person.
- For prescription drug claims, the pharmacy receipt should include the NDC number, name of drug, quantity and dosage.
- To file charges for more than one patient, even if the charges are all on one bill, please:
 - Complete a separate form for each patient AND attach a separate copy of the provider's bill to each patient's form, if needed.
 - If a claim is submitted for services rendered by an Out of State Provider, we may forward your claim to the appropriate Blue Card Plan to be processed.
- Mall all forms to: Blue Cross of Idaho Health Service, Inc.
Box 7408
Boise, Idaho 83707

You should hear from us in about three weeks or less. Please do not re-submit these charges to us in the meantime.

PATIENT AND ENROLLEE INFORMATION		
Patient's Name (First Name, Middle Initial, Last Name)	Patient's Date of Birth	Enrollee's Name (First Name, Middle Initial, Last Name)
Do you or any of your dependents have other health coverage? (This includes other Blue Cross and Blue Shield coverage as well as Medicare.) <input type="checkbox"/> YES <input type="checkbox"/> NO	Patient's Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Enrollee's Blue Cross of Idaho Identification Number (with Alpha Prefix)
Type of Coverage If Medicare <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Part A <input type="checkbox"/> Part B <input type="checkbox"/> Part D	Patient's Relationship to Enrollee <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	Enrollee's Group No. (or Program Number)
Coverage is for (Check all applicable boxes) <input type="checkbox"/> Enrollee <input type="checkbox"/> Spouse <input type="checkbox"/> Children	ID Number with Other Carrier	Enrollee's Address (Street, City, State, Zip Code)
Name and Address of Other Carrier	Group Number/Name with Other Carrier	
Was this condition the result of an accident? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> If NO, enter date of service, sign at the bottom, and return the form to us.	Effective Date with Other Carrier	
Date of Service		

ACCIDENTAL INJURY INFORMATION (Please complete if claim is related to an injury)

Date of Injury mm/dd/yy	Describe how and where the injury occurred.		
To your knowledge, who was responsible for the accident?	Have you received settlement from the responsible party? <input type="checkbox"/> YES <input type="checkbox"/> NO	Do you intend to make a claim against the responsible party? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> POSSIBLY	
Is an attorney representing you in this matter? If so, please give your attorney's name and address. (Blue Cross of Idaho may be contacting your attorney regarding this matter.)			
Was the condition the result of an auto accident? <input type="checkbox"/> YES <input type="checkbox"/> NO			
Was this injury or illness sustained while performing work required by the patient's employment? <input type="checkbox"/> YES <input type="checkbox"/> NO (If your claim is work-related and you have received a denial please attach a copy.)			
Is the patient covered by Workers' Compensation? <input type="checkbox"/> YES <input type="checkbox"/> NO	Is the patient self-employed? <input type="checkbox"/> YES <input type="checkbox"/> NO	Has the patient filed a claim with the Industrial Accident Commission? <input type="checkbox"/> YES <input type="checkbox"/> NO	Has the patient notified his or her employer of this condition? <input type="checkbox"/> YES <input type="checkbox"/> NO
Is the patient covered by a liability coverage other than Workers' Compensation for work-incurred injuries? <input type="checkbox"/> YES <input type="checkbox"/> NO		Has the patient filed a claim with his or her employer's liability coverage? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Signature of Enrollee	Make Payment to <input type="checkbox"/> Enrollee (Attach proof of payment) <input type="checkbox"/> Provider	Date Submitted	

WARNING: Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information, is guilty of a felony. In cases of proven fraud, Blue Cross of Idaho will terminate agreements for services and benefits, seek restitution of dollars lost, and pursue criminal prosecution to the full extent of the law.

THANK YOU FOR YOUR HELP

Form No. 5-175 (08-06)