Submitting a Health Insurance Claim Form

If you are seeing a medical provider who is not in network with your insurance company, you will have to obtain an itemized bill from that provider, and submit your own claim form in order to receive reimbursement. The amount reimbursed will vary by plan.

<u>Step One: Itemized Bill</u>

Ask your provider for an itemized bill that specifies the dates of service, charges for each service, type(s) of service (e.g., procedure code), and the diagnostic code (e.g., from the ICD-10 or DSM-5) for the condition treated. It must also include identifying information about both the patient and the provider (such as their name, address, and tax identification number). An insurance company will not reimburse you without such a bill. Do not write on, highlight, or in any way modify this itemized bill. If you notice an inaccuracy or error, ask your provider for a corrected copy.

<u>Step Two: Claim Form</u>

Download a claim form from your insurance company's website. An example claim form from Premera can be found on the backside of this paper. Complete the form carefully.

<u>Step Three: Make Copies</u>

Whether you submit your paperwork electronically or by mail, make copies before sending anything. In the event that your paperwork is lost, or your claim is denied because of an error (either by you or your provider), having copies will make re-submitting much easier.

<u>Step Four: Review and Submit</u>

It is recommended that you call your insurance company and make sure you have all the paperwork you need. You may also ask them for an estimate of when you can expect your claim to be processed, and plan to follow-up with them if you have not heard anything by that date.

P.O. Box 91059
Seattle, WA 98111-9159

Member Submitted Claim Form

This form is to be used for **medical**, **vision**, and **dental claims** where you incurred expenses from a provider who did not bill the plan directly. **Do not use this form for prescription reimbursement.** Please use the Prescription Drug Reimbursement Form (for primary prescription claim submission) or the Secondary Insurance Prescription Drug Claim Form.

See instructions on other side for additional information to complete your claim.

1. Patient / Member

Prefix and ID number (see ID card)	Group number (see ID card)	Patient name (first, middle, last)	Date of birth (month/day/year)

Address	City	State	ZIP

Home phone number	Work or alternate phone number	Subscriber name (first, middle, last)

Does the patient have coverage from any other health plan?
☐ No, skip to section 2 ☐ Yes, please attach the Explanation of Benefits (EOB) statement from the primary plan with this claim, and complete the following information.

Name of other health plan	ID number or policy number of other health plan	Phone number of other health plan

2. Claim Details

NOTE: You must submit an itemized bill or your claim will be returned.

Have the charges been paid in full?
☐ No ☐ Yes, please attach proof of payment in full with your itemized bill.

In what setting were these services performed?
☐ Inpatient hospital ☐ Outpatient hospital ☐ Office/clinic ☐ Surgery center ☐ Skilled nursing facility ☐ Home ☐ Other:

3. International Claim

NOTE: You must submit an itemized bill or your claim will be returned.

Is this claim for expenses incurred outside the U.S.A.?
☐ No, skip to section 4 ☐ Yes, please attach an itemized bill, available medical records, and complete this section.

Name of provider	Type of provider ☐ Hospital ☐ Lab ☐ Office ☐ X-ray	Country of service	City of service	Date of service

Diagnosis (describe illness and symptoms requiring treatment)	Charges	Currency used

4. Accident / Injury

Is this claim due to an accidental injury? ☐ No, skip to section 5 ☐ Yes, complete this section	Date of accident	Where did the accident occur? ☐ Home ☐ Work ☐ School ☐ Auto ☐ Other:

How did the accident happen?

Description of injury

5. Signature

To be accepted, this form must be fully completed (as appropriate to the claim being submitted), signed, and have an itemized bill attached.

Mail to: Premera Blue Cross, P.O. Box 91059, Seattle, WA 98111-9159

Patient signature (or legal guardian if patient cannot legally consent to services)	Relationship to patient ☐ Self ☐ Other:	Date (month/day/year)

Please note: *It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.*

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