



**BlueCross BlueShield
of Wyoming**

4000 House Avenue • P. O. Box 2266
Cheyenne, WY 82003-2266

An independent licensee of the Blue Cross
and Blue Shield Association.

MEDICAL CLAIM FORM

(Instructions for filing on second page)

PARTICIPANT'S NAME (Last, First, Middle)		ALPHA PREFIX □□□	BCBS CARD NUMBER □□□□□□□□□□			
HOME ADDRESS (Street, City, State, Zip)					IS THIS A NEW ADDRESS? <input type="checkbox"/> YES <input type="checkbox"/> NO	
PATIENT'S NAME (Last, First, Middle)	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	DATE OF BIRTH ____/____/____ <small>Month / Day / Year</small>	RELATIONSHIP TO PARTICIPANT	<input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD		

DESCRIBE THE ILLNESS, INJURY OR SYMPTOMS REQUIRING TREATMENT _____

IF ILLNESS OR INJURY RESULTED FROM AN ACCIDENT, WAS IT DUE TO: AUTO <input type="checkbox"/> EMPLOYMENT <input type="checkbox"/> OTHER <input type="checkbox"/>	INDICATE DATE OF ACCIDENT ____/____/____
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IF OTHER, BRIEFLY DESCRIBE _____

IF CLAIM FOR DEPENDENT CHILD OVER AGE 19, ARE THEY: <input type="checkbox"/> FULL-TIME-STUDENT <input type="checkbox"/> PART TIME STUDENT <input type="checkbox"/> OTHER	IF STUDENT, PLEASE GIVE NAME & LOCATION OF SCHOOL ATTENDING: DATE OF SCHOOL ENROLLMENT: _____
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OTHER HEALTH INSURANCE:
Is the patient covered by additional health insurance through an employer, a group such as a professional organization or any other group health insurance, including other Blue Cross and/or Blue Shield Coverage? YES NO
If yes, please complete this section.

NAME AND ADDRESS OF INSURING COMPANY (Street, City, State, Zip)		EFFECTIVE DATE ____/____/____ <small>Month / Day / Year</small>	TERMINATION DATE ____/____/____ <small>Month / Day / Year</small>
NAME OF POLICYHOLDER (Last, First, Middle)	DATE-OF-BIRTH ____/____/____ <small>Month / Day / Year</small>	IDENTIFICATION NUMBER (Including all letters & numbers)	
POLICYHOLDER'S EMPLOYER IF EMPLOYMENT, PLEASE GIVE NAME AND ADDRESS OF EMPLOYER _____			

I certify that the above is correct and complete and that I am claiming benefits *only* for the charges incurred by the patient named above.

INSTRUCTIONS FOR FILING CLAIMS

1. A separate claim form must be submitted for each family member.
2. Itemized bills for covered services, supplies and durable medical equipment **MUST** be attached and show:
 - A. Name of patient and date of birth
 - B. Date of service and charge for each
 - C. Type of services/supplies/equipment received (surgery, office calls, crutches, etc.)
 - D. Description of illness or accident
 - E. Date of accident
3. Bills for prescription medication must include above information as well as:
 - A. Patient's Name
 - B. Description of Illness or Accident
 - C. Name of Drug
 - D. Name of Drug Store
 - E. Prescribing Physician
 - F. Date Purchased and Charge for Each Drug
 - G. If actual drug receipt is not available, pharmacist signature is required
3. Questions on filing medical claims should be directed to:

*Customer Service Center
Blue Cross Blue Shield of Wyoming
P. O. Box 2266
Cheyenne, WY 82003-2266
307.634.1393
1.800.442.2376 (in Wyoming)*

NOTE: Balance due statements, cash register receipts, cancelled checks and cash receipts are **not** acceptable.

ITEMIZED BILLS CANNOT BE RETURNED

SAMPLE OF BCBS IDENTIFI-

CATION CARD

DOE JOHN F	(subscriber name)
ZSA 000000000	(BCBS-card number)
XXXXX	960 460