

Health Insurance Claim Number Form (HIC #)

Instructions: Please complete this form and return it to Regence BlueShield. You may also provide us with this information by calling 800-422-7713. Please be sure you can provide us with all of the information listed below at the time of your call.

1. Name: _____
2. Member ID: _____
(From your Member card)
3. Address: _____

4. Phone Number: _____
5. Your Medicare Health Insurance Number (HIC #) including the alpha prefix, or suffix, and the effective dates as indicated on your Medicare card.
 - A. HIC #: _____
 - B. Part A (hospital coverage) effective date: _____
 - C. Part B (medical coverage) effective date: _____
6. The reason for your Medicare entitlement (please check one):
I am over age 65: Yes___ No___
I am Disabled: Yes___ No___ Effective Date of Disability: ___/___/___
I have End Stage Renal Disease: Yes___ No___ Date of First Dialysis: ___/___/___

If your spouse or dependent is also Medicare-eligible and enrolling in your Plan, please complete the following information for your spouse or dependent:

1. Name: _____
2. Spouse or dependent Medicare Health Insurance Number (HIC #) including the alpha prefix, or suffix, and the effective dates as indicated on the Medicare card.
 - A. HIC #: _____
 - B. Part A (hospital coverage) effective date: _____
 - C. Part B (medical coverage) effective date: _____
3. The reason for your spouse or dependents Medicare entitlement (please check one):
I am over age 65: Yes___ No___
I am Disabled: Yes___ No___ Effective Date of Disability: ___/___/___
I have End Stage Renal Disease: Yes___ No___ Date of First Dialysis: ___/___/___

Signature: _____ Date: _____

Print Name: _____

It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purposes of defrauding the company. Penalties include imprisonment, fines, and denial of insurance.