INSTRUCTIONS

Most providers will bill directly for you and no claim form will be necessary. However, if you do incur expenses from a provider who will not bill the plan directly, please follow these instructions.

A. Please do not use more than one provider or patient per claim (you may use multiple dates of service for one patient).

B. If you have been provided an itemized statement/bill, confirm all of the following information is on it and simply file the statement/bill according to the instructions in section E or F.

An itemized statement/bill is one that includes: patient's name, member ID and alpha prefix (found on your Member ID card), date of service, type of service rendered (the procedure), nature of condition being treated (the diagnosis) and charge for each service. It will also include the provider's name, address, phone number and taxpayer identification number.

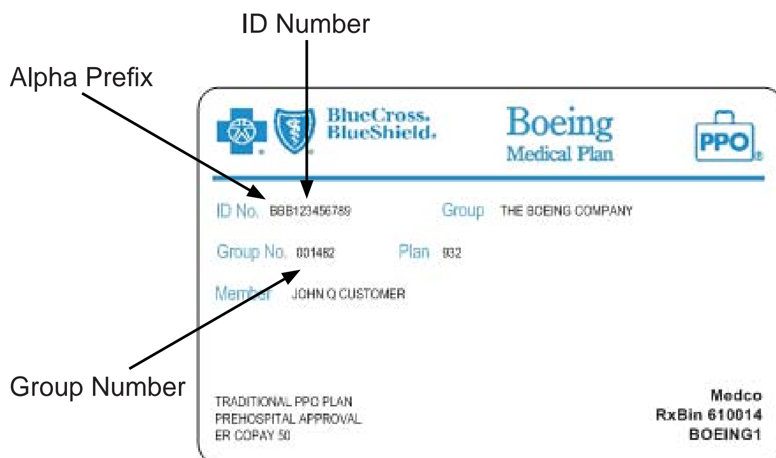
C. If you don't have a statement or if any of the above information is missing from the statement, please contact your provider to obtain the information. If you receive a complete itemized statement, file the claim according to the instructions in sections E or F. If it is incomplete and you have the information, please fill out this claim form with the missing information. Please remember to sign the form.

D. If you have filled out the member claim form, please attach a copy of your statement when submitting the claim.

E. If services were rendered in **Western Washington**, please submit completed claim forms to:

Regence BlueShield
PO Box 21065
Seattle, WA 98111-3065

F. If services were rendered **outside of Western Washington**, please submit the claim form to the Blue Cross or Blue Shield plan in the area where services were rendered. If you need help locating the address of that plan, or have questions about the claim form, please contact Regence BlueShield at 1-800-422-7713.



The Member ID card pictured above may not match your particular identification card. This map is meant to be a guide to help you identify your alpha prefix, member and group numbers.

You can research your claims, view eligibility information, order Member ID cards and utilize Live Help by visiting our self-service Web site myRegence.com.

MEDICAL CLAIM FORM

Regence BlueShield is an Independent Licensee of the Blue Cross and Blue Shield Association

1800 Ninth Avenue
PO Box 21065
Seattle, WA 98111-3065

1. PATIENT INFORMATION

NAME (FIRST, MIDDLE, LAST)

ADDRESS (IF DIFFERENT THAN SUBSCRIBER'S)

CITY | STATE | ZIP

SEX: ❒ MALE ❒ FEMALE

DATE OF BIRTH (MONTH/DAY/YEAR)

DOES THE PATIENT HAVE OTHER HEALTH INSURANCE COVERAGE? ❒ YES ❒ NO

NAME OF OTHER HEALTH INSURANCE COMPANY & TELEPHONE NUMBER

POLICY NUMBER

GROUP NUMBER

CONTACT PHONE NUMBER

PATIENT RELATION TO SUBSCRIBER

2. SUBSCRIBER INFORMATION

NAME (FIRST, MIDDLE, LAST)

ADDRESS

CITY | STATE | ZIP

ALPHA PREFIX PLUS ID NUMBER (SEE ID CARD)

PATIENT'S NUMBER (SSN, ID#, ETC)

GROUP NUMBER (SEE ID CARD)

HOME TELEPHONE NUMBER

WORK TELEPHONE NUMBER

3. ACCIDENT / INJURY INFORMATION (Complete only if the claim was due to an accidental injury.)

ACCIDENT DATE

TIME AM/PM

DID YOUR INJURY OCCUR WHILE AT WORK? ❒ YES ❒ NO

HOW DID THE ACCIDENT HAPPEN?

DESCRIPTION OF INJURY

DID ANOTHER PERSON CAUSE THIS ACCIDENT? ❒ YES ❒ NO

CAN THIS PERSON BE CONSIDERED LEGALLY RESPONSIBLE FOR YOUR INJURIES? ❒ YES ❒ NO

4. EMPLOYEE / RETIREE RELEASE INFORMATION

To all providers, hospitals and other health care institutions: You are authorized to provide any independent claim administrators and consulting health professionals and utilization review organizations with whom Blue Cross or Blue Shield has contracted, information concerning health care, advice, treatment or supplies provided the patient (including that relating to mental illness). This information will be used for the purpose of evaluating and administering claims for benefits. Blue Cross or Blue Shield may provide the employer named below with any benefit calculation used in payment of this claim for the purpose of reviewing the experience and operation of the policy or contract. This authorization is valid for the term of coverage of the policy or contract under which a claim has been submitted. I know that I have a right to receive a copy of this authorization upon request and agree that a photographic copy of this authorization is as valid as the original.

DATE ________ EMPLOYEE/RETIREE/PATIENT OR AUTHORIZED PERSON'S SIGNATURE ________

Any person who, knowingly and with intent to defraud or deceive the Boeing company, files a statement of claim containing any materially false, incomplete or misleading information is guilty of a crime.

5. AUTHORIZATION TO PAY PROVIDER OF SERVICE(S)

I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO THE PHYSICIAN OR SUPPLIER FOR SERVICE DESCRIBED BELOW (IF ALLOWED BY THE PARTICIPATING BLUE CROSS OR BLUE SHIELD PLAN).

SUBSCRIBER/PATIENT OR AUTHORIZED PERSON'S SIGNATURE ________

6. MEDICAL INFORMATION

PROVIDER OF SERVICE (NAME, ADDRESS, PHONE NUMBER)

NATIONAL PROVIDER IDENTIFIER (NPI) NUMBER
(NOTE: MAY NOT BE REQUIRED FOR PAPER SUBMISSION)

TAX IDENTIFICATION NUMBER (REQUIRED)

PATIENT'S ACCOUNT NUMBER

DATE OF SERVICE	PLACE OF SERVICE	DIAGNOSIS CODE(S)	DESCRIPTION OF PROCEDURES, MEDICAL SERVICES OR SUPPLIES			DAYS OR UNITS	CHARGES	REMARKS
			Procedure Code	Modifier	Description			

TOTAL CHARGES	AMOUNT PAID BY OTHER INSURANCE	AMOUNT PAID BY PATIENT	BALANCE DUE
$	$	$	$

SUBSCRIBER/PATIENT or PROVIDER'S SIGNATURE ________

DATE ________