



# DIRECT MEMBER REIMBURSEMENT FORM

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

Thank you for choosing us for your health insurance coverage. Use this claim form for any reimbursement requests you may have. If you received services from a participating provider, your claim should be submitted by the provider; therefore, you do not need to submit this form unless you know that your claim was not submitted. Please complete a separate form for each family member, pharmacy or provider (print additional copies of page 2 if necessary). **For claim filing time limits, review your benefit information.**

1. Complete the information below and where indicated on the following page.
2. Write your ID number on the top of each page.
3. Tape your original receipts in the boxes marked for receipts; cash register receipts will not be accepted.
4. Retain copies of receipts for your records. Receipts will not be returned.
5. Sign the completed form where indicated at the bottom of this page and mail to:  
Regence BlueShield of Idaho  
PO Box 1106  
Lewiston, ID 83501-1106

MEMBER INFORMATION					
Patient's Name (Last, First, M.I.)			Patient's Date of Birth		Patient's Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
Policyholder's Name (Last, First, M.I.)				Patient's Relationship to Policyholder <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent	
Policyholder's Street Address		City	State	ZIP Code	Telephone Number
Patient's ID Number (3 letters followed by 9 numbers)			Group Name		Group Number

OTHER INSURANCE INFORMATION					
Are you or ANY family members on this policy covered by other:					
Medical coverage?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Vision Coverage?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Dental coverage?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	With Orthodontia?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Prescription Coverage?	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
If YES, is this coverage <input type="checkbox"/> Group <input type="checkbox"/> Individual					
Are you or any family members covered by Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No    If YES: <input type="checkbox"/> Part A <input type="checkbox"/> Part B <input type="checkbox"/> Part D					
IF THE ANSWER TO ANY OF THE ABOVE QUESTIONS IS "YES," please complete the section regarding the other insurance.					
If there are more than one additional policy, attach the requested information for each policy on a separate sheet of paper.					
Name of Other Insurance		Subscriber's Name		ID Number	Date of Birth
Subscriber's Relationship to Regence Policyholder					
Street Address for Submitting Claims			City	State	ZIP Code
This other insurance covers: <input type="checkbox"/> Regence Policyholder's Spouse <input type="checkbox"/> Regence Policyholder <input type="checkbox"/> Dependents			If covered children are from divorced parents, indicate name of person with legal custody		
Name of Subscriber's Employer			<input type="checkbox"/> Active <input type="checkbox"/> Retiree	Effective Date of this Plan	

Please indicate why the patient paid in cash \_\_\_\_\_

I certify that the above statements are correct and hereby authorize any physician, dentist, hospital, employer, union, insurance company, or prepayment organization to supply my employer and its agents any information required in connection with this claim. A photocopy of this authorization shall be as valid as the original.

Signature (Subscriber or Patient) \_\_\_\_\_

Date \_\_\_\_\_

**Prescription (Rx) receipts must contain:**

Rx Number  
Date Rx was filled  
Provider's Name  
Drug Name and NDC Number  
Quantity and days supply  
Charge

**Medical, Dental and Vision receipts must contain:**

Provider's Name and Address  
National Provider Identifier  
Diagnosis and Procedure Codes  
Date of Service  
Itemized Charges

**Contact the provider or pharmacy if you need additional information**

**TAPE RECEIPT HERE**  
**In date order**

\_\_\_\_\_  
Nature of Illness or Injury

\_\_\_\_\_  
Doctor's Name (If not on receipt)

\_\_\_\_\_  
If Injury, Date Occurred

\_\_\_\_\_  
How, When, Where

**TAPE RECEIPT HERE**  
**In date order**

\_\_\_\_\_  
Nature of Illness or Injury

\_\_\_\_\_  
Doctor's Name (If not on receipt)

\_\_\_\_\_  
If Injury, Date Occurred

\_\_\_\_\_  
How, When, Where