Regence

Regence BlueShield serves select counties in the state of Washington
and is an Independent Licensee of the Blue Cross and Blue Shield Association

MEMBER REIMBURSEMENT FORM

Thank you for choosing Regence for your health care coverage.

Please review the filing instructions located at the end of this form before you begin for helpful information regarding how to complete your claim so that it will process quickly and accurately.

Contact customer service using the toll-free number on your Regence Member Identification card if you have any questions, or communicate with the Live Help team on regence.com for on-line assistance. We are happy to serve you.

MEMBER INFORMATION

Patient's Name (Last, First, M.I.)	Patient's Date of Birth (mm/dd/yyyy) (mm/dd/yyyy)	Patient's Sex ☐ Male ☐ Female
Policyholder's Name (Last, First, M.I.)		Patient's Relationship to Policyholder ☐ Self ☐ Spouse ☐ Dependent

Policyholder's Address	City	State State	ZIP Code xxxxx-xxxx	Telephone Number (xxx) xxx-xxxx

Patient's ID Number (3 letters followed by 9 numbers)	Group Name	Group Number

Does the patient have coverage from any other health plan including Medicare?

☐ No. Please skip to Claim Details.

☐ 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 / Policy Number of Other Health Plan	Telephone Number of Other Health Plan (xxx) xxx-xxxx

CLAIM DETAILS

Name of Provider	Address where services were rendered	Date of Service (mm/dd/yyyy) (mm/dd/yyyy)

Diagnosis (describe illness and symptoms requiring treatment):	Total Charges

Briefly describe the service(s) you received:

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_____

If applicable, list the contact information of the physician that prescribed/ordered these services:

Name	Address	Telephone Number (xxx) xxx-xxxx

INTERNATIONAL SERVICES

Is this claim for expenses incurred outside the U.S.A.?

☐ No. Please skip to Accident / Injury. ☐ Yes. Please supply an itemized bill and any available medical records when you submit the claim.

Name of Provider	Country of Service	City of Service	Date of service (mm/dd/yyyy) (mm/dd/yyyy)

Diagnosis (describe illness and symptoms requiring treatment):	Total Charges	Currency Used

Briefly describe the service(s) you received:

ACCIDENT / INJURY

Is this claim due to an accidental injury?	Date of accident (mm/dd/yyyy)	Where did the accident occur?
☐ No. Please skip to Signature. ☐ Yes. Please complete this section.	(mm/dd/yyyy)	☐ Home ☐ Work ☐ School ☐ Auto ☐ Other

How did the accident happen?

Description of injury:

Please Note: If there is another party that may be responsible to pay for these services, such as homeowner's or auto insurance, please finish submitting your claim then contact an agent in our Other Party Liability department at 877-633-7877 to assist you further.

SIGNATURE

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

Patient Signature (or legal guardian if patient cannot legally consent to services)	Relationship to Patient	Date (mm/dd/yyyy)
▶	☐ Self ☐ Other	(mm/dd/yyyy)

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.

I certify that the above statements are correct and hereby authorize any physician, 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.

▶ _____ (mm/dd/yyyy) _____

Signature (Subscriber or Patient) Date

Thank you for choosing Regence as your health plan administrator. We recommend that you make copies of everything that is submitted for your personal records.

Mail this claim to:
Regence BlueShield
PO Box 1106
Lewiston, Idaho 83501

INSTRUCTIONS FOR FILING A CLAIM

IMPORTANT:

- Use this form for all medical, pharmacy, dental, and vision services covered by Regence. If your policy utilizes a vendor for pharmacy, dental or vision services, contact the vendor for any necessary forms or instructions for filing your claim.
- If the services were rendered on a cruise ship or are related to a prescriptions purchase made outside of the United States, you may proceed using this form. All other service types rendered outside of the United States will need to be filed on the BlueCard Worldwide International Claim Form and submitted according to the instructions provided. Visit **www.bluecardworldwide.com** for additional information.
- You only need to fill out this form if your health care professional isn't filing the claim for you. Your health care professional can still file the claim for you if they are out-of-network with your policy; however, they are not required to do so.
- Payment is made directly to contracting health care professionals. We only send payment to you when the health care professional is out of network and there is evidence that you have paid in full for the services rendered.
- If services are a result of an accident or injury, complete the Accident/Injury section of the claim form. If there is another party that may be responsible to pay for these services, such as homeowner's or auto insurance, please contact an agent in our Other Party Liability department at 877-633-7877 to assist you further. You may still continue with your claim submission.
- If you have Medicare or other insurance coverage that is not already on file with Regence, or if it has changed or terminated, you will need to contact Regence to update your account to ensure your claim processes correctly and timely.

FILING RECOMMENDATIONS:

- Complete a separate claim form for each covered family member.
- Enclose itemized receipts and make copies for your records. It is helpful for receipts to include:
  Patient's Name
  Date of Service (mm/dd/yy)
  Procedure Code(s)
  Diagnosis Code(s) - ICD Format
  Health care professional's Full Name, Credentials, Address, Phone Number and Tax ID Number and National Provider Identifier (NPI)
  Total charge for each service rendered
- If the patient has Medicare or other health insurance coverage, and that other insurance coverage is primary and Regence is secondary, we need an Explanation of Benefits (EOB) for this service from the other insurance company when you send the completed form and itemized bill.