BlueCross BlueShield of Vermont

An Independent Licensee of the Blue Cross and Blue Shield Association.

MEMBER CLAIM FORM

www.bcbsvt.com

Complete all fields on this form and attach an itemized statement from your provider. We can't process your claim without an itemized invoice. Please note that you must submit a separate claim for each family member and a separate claim form for each provider. See back of form for additional instructions.

PATIENT INFORMATION

Patient's Name (Last, First)	**Patient's Date of Birth** (MO | DAY | YR)	**BCBSVT ID Number** from ID card Prefix (ex: ZII) | Number (ex: V812345678000)
Patient's Phone including area code	**Patient's Gender** ☐ MALE ☐ FEMALE	**Patient's Address** Street: City: State: Zip:
Health Plan Subscriber's Name (Last, First)	**Patient's Relationship to Subscriber** ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER	
Health Plan Subscriber's Date of Birth	**Health Plan Group Number**	**Is this an employer-based health plan?** ☐ YES ☐ NO

PROVIDER INFORMATION

Provider and Practice/Facility Name	Provider's Address Street: City: State: Zip:	Provider's ID Numbers NPI Tax ID License Number State Issued
Provider's Phone including area code		
Ordering or Referring Provider and State Located Name State		

ADDITIONAL INFORMATION

Was the condition related to the patient's employment? ☐ YES ☐ NO If yes, include date of injury:	Was the condition related to an accident or injury involving another party? ☐ YES ☐ NO If yes, include date of accident or injury:	Other insurance company name and phone number Name: Phone including area code

CLAIM INFORMATION (Please work with your provider to fill in the shaded areas.)

Date of service (MO | DAY | YR)	Description of Service	Procedure Code	Modifier	Diagnosis Code	Charge	Units	POS
	Homemaker Services	BB3		Z39.2	$		12
	hours/day_____ amt/hour $_____				$		
	hours/day_____ amt/hour $_____				$		
	hours/day_____ amt/hour $_____				$		
	hours/day_____ amt/hour $_____				$		
	hours/day_____ amt/hour $_____				$		
				Total Bill:	$		

I authorize any hospital, physician or other provider to release to Blue Cross and Blue Shield of Vermont any information deemed necessary to process my claim for benefits. 1250.01: The person signing this form understands that the willful making of a false or fraudulent statement herein renders him/her liable to prosecution.

Signature of Member or Subscriber: _____ Date signed: _____

Save document **Submit Form**

BlueCross BlueShield of Vermont

An Independent Licensee of the Blue Cross and Blue Shield Association.

MEMBER CLAIM FORM

www.bcbsvt.com

Please follow these instructions carefully and email your completed form with all attachments to:

Blue Cross and Blue Shield of Vermont, Attn: Claims, at CustomerService@bcbsvt.com.

We will return all incomplete claims. Please note that in most instances we aren't allowed to contact out-of-state and/or out-of-network providers to collect missing information.

1. Itemized bills must be on the provider's letterhead and include:
    - The name of the patient
    - The name of the person or place providing the service
    - The provider's National Provider Identifier (NPI) and tax ID number
    - The date of each service
    - The description of each service performed (including the corresponding CPT® or HCPCS® code)
    - The charge for each service
    - The patient's diagnosis for the service provided (including the corresponding ICD-10 code)
    - The place of service (e.g.: office, outpatient facility, clinic, etc.) and the corresponding Place of Service (POS) code
2. Use a separate form (photocopies are acceptable) if you are submitting more than six services with the same provider. Please do not highlight any information on the form or attachments.
3. Secondary Claims—If you have another primary insurance (including Medicare) and are submitting secondary balances, you must attach the primary carrier explanation of benefits or denial/opt out letter.
4. Please note that you must submit prescription drugs purchased at a pharmacy on a Prescription Reimbursement/Drug Claim Form directly to the pharmacy benefits manager.
5. Please submit your claim as soon as you incur any medical expenses.

Please keep a copy of the completed claim form and the itemized invoice for your own records.

Other information

Blue Cross and Blue Shield of Vermont issues payments for member-payable claims to the health plan benefits subscriber.

To view processed claims, login to our secure Member Resource Center at bcbsvt.com/MRC. The Member Resource Center enables you to view and print detailed claim and benefit information, order ID cards, print proof of your coverage, securely e-mail our customer service team and more.

If you have any questions or need help completing of this form, please contact our customer service team toll-free at (800) 247-2583 or at the number on the back of your ID card. Out-of-state callers, please use (800) 395-3389.

NOTICE: Discrimination is against the law

Blue Cross and Blue Shield of Vermont (BCBSVT) and its affiliate The Vermont Health Plan (TVHP) comply with applicable federal and state civil rights laws and do not discriminate, exclude people or treat them differently on the basis of race, color, national origin, age, disability, gender identity or sex.

BCBSVT provides free aids and services to people with disabilities to communicate effectively with us. We provide, for example, qualified sign language interpreters and written information in other formats (e.g., large print, audio or accessible electronic format).

BCBSVT provides free language services to people whose primary language is not English. We provide, for example, qualified interpreters and information written in other languages.

If you need these services, please call (800) 247-2583. If you would like to file a grievance because you believe that BCBSVT has failed to provide services or discriminated on the basis of race, color, national origin, age, disability, gender identity or sex, contact:

Civil Rights Coordinator
Blue Cross and Blue Shield of Vermont
PO Box 186
Montpelier, VT 05601
(802) 371-3394
TDD/TTY: (800) 535-2227
civilrightscoordinator@bcbsvt.com

You can file a grievance by mail, or email at the contacts above. If you need assistance, our civil rights coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

U.S. Department of
Health and Human Services
Office for Civil Rights
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
(800) 368-1019
(800) 537-7697 (TDD)

For free language-assistance services, call (800) 247-2583.

ARABIC

للحصول على خدمات المساعدة اللغوية المجانية، اتصل على الرقم (800) 247-2583.

CHINESE

如需免費語言協助服務，請致電(800) 247-2583。

CUSHITE (OROMO)

Tajaajila gargaarsa afaan hiikuu kaffaltii malee argachuuf (800) 247-2583 bilbilaa.

FRENCH

Pour obtenir des services d'assistance linguistique gratuits, appelez le (800) 247-2583.

GERMAN

Kostenlose fremdsprachliche Unterstützung erhalten Sie unter (800) 247-2583.

ITALIAN

Per i servizi gratuiti di assistenza linguistica, chiamare il numero (800) 247-2583.

JAPANESE

無料の通訳サービスのご利用は、(800) 247-2583までお電話ください。

NEPALI

निःशुल्क भाषा सहायता सेवाहरूका लागि, (800) 247-2583 मा कल गर्नुहोस्।

PORTUGUESE

Para serviços gratuitos de assistência linguística, ligue para o (800) 247-2583.

RUSSIAN

Чтобы получить бесплатные услуги переводчика, позвоните по телефону (800) 247-2583.

SERBO-CROATIAN (SERBIAN)

Za besplatnu uslugu prevođenja, pozovite na broj (800) 247-2583.

SPANISH

Para servicios gratuitos de asistencia con el idioma, llame al (800) 247-2583.

TAGALOG

Para sa libreng mga serbisyo ng tulong pangwika, tumawag sa (800) 247-2583.

THAI

สำหรับการให้บริการความช่วยเหลือด้านภาษาฟรี โทร (800) 247-2583

VIETNAMESE

Để biết các dịch vụ hỗ trợ ngôn ngữ miễn phí, hãy gọi số (800) 247-2583.