BlueCross BlueShield of Nebraska

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

SUBSCRIBER'S CLAIM FORM
*Non-Participating Provider

**Participating Providers should file charges on your behalf*

PLEASE CHECK ONE: ☐ Medical Claim ☐ Dental Claim

NOTE: Rx Drugs must be submitted on Prescription Drug Claim Form 8009 (12-21-10)

Please check with the physician to verify the charges have not been submitted.
ONE CLAIM FORM PER PATIENT, PER PROVIDER. See reverse side for further instructions.

INSTRUCTIONS: Print or type clearly and accurately. If you are completing this form in Acrobat, simply "tab" from field to field.

SUBSCRIBER INFORMATION

1. BCBSNE ID Number: (ALPHA PREFIX) (NUMBERS)
2. Subscriber's Daytime Phone Number: (AREA CODE) – (TELEPHONE NUMBER)
3. Subscriber's Name: (LAST NAME) (FIRST NAME) (M.I.)
4. Subscriber's Address: Street: City: State: Zip: –
5. Date of Birth: (PLEASE ENTER AS — MMDDYYYY)
6. Sex: ☐ Male ☐ Female

PATIENT INFORMATION

7. Patient's Name: (LAST NAME) (FIRST NAME) (M.I.)
8. Patient's Address: Street: City: State: Zip: –
9. Date of Birth: (PLEASE ENTER AS — MMDDYYYY)
10. Sex: ☐ Male ☐ Female
11. Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

SERVICE INFORMATION

12. Was service related to employment? ☐ Yes ☐ No
13. Was service related to auto accident? ☐ Yes ☐ No If YES, date of accident: (PLEASE ENTER AS — MMDDYYYY)
14. OTHER type of accident? ☐ Yes ☐ No If YES, list other: _____
15. Was service performed in Nebraska? ☐ Yes ☐ No
16. TO AVOID ANY DELAY IN THE PROCESSING OF YOUR CLAIM, attach the following information:

- ▶ An itemized bill that includes the provider's complete name and address, dates of service, charges and any procedure and diagnosis codes, and the following:

  Tax ID Number: NPI Number:

- ▶ Other insurance Explanation of Benefits (if applicable).
- ▶ For Dental claims, additional information may be requested from the provider.

NOTE: Balance forward statements, cancelled checks, cash register receipts and self-itemizations do not have all the information needed and will cause a delay in the handling of your claims.

I certify the above is complete and correct, and that I am claiming benefits for charges incurred by the above named patient.

SUBSCRIBER SIGNATURE _____ DATE _____

NOTE: A separate claim form must be completed for each patient and each provider. Please check with your provider of care to determine if charges have already been filed.

SUBSCRIBER INFORMATION:

1. BCBSNE ID NUMBER: Enter the identification number and any alpha prefix as shown on your Blue Cross and Blue Shield ID Card. (If you are age 65 or older, this number may not be the same as your Medicare number).

2. SUBSCRIBER'S DAYTIME PHONE NUMBER: The area code and phone number of the subscriber. This can be a landline or cell number.

3. SUBSCRIBER'S NAME: Enter the subscriber's name as shown on subscriber's ID card.

4. SUBSCRIBER'S ADDRESS: Enter the home address of the subscriber.

5. SUBSCRIBER'S DATE OF BIRTH: Enter the date of birth of the subscriber providing the month as two digits (MM), day as two digits (DD) and year as four digits (YYYY).

6. SUBSCRIBER'S SEX: Check the appropriate box for the sex of the subscriber.

PATIENT INFORMATION

7. PATIENT'S NAME: Enter the patient's FULL LEGAL NAME (not a nickname); please include "Sr." or "Jr." if applicable.

8. PATIENT'S ADDRESS: Enter the home address of the patient.

9. PATIENT'S DATE OF BIRTH: Enter the date of birth of the patient providing the month as two digits (MM), day as two digits (DD) and year as four digits (YYYY).

10. PATIENT'S SEX: Check the appropriate box for the sex of the patient.

11. PATIENT'S RELATIONSHIP TO SUBSCRIBER: Check the appropriate box to indicate the relationship of the patient to the subscriber.

SERVICE INFORMATION

12. WAS THE SERVICE RELATED TO EMPLOYMENT? Check the appropriate box to indicate if the service was due to an accident or illness related to employment.

13. WAS THE SERVICE RELATED TO AN AUTO ACCIDENT? Check the appropriate box to indicate if the service was the result of an auto accident.

14. OTHER TYPE OF ACCIDENT? Check the appropriate box to indicate if the service was related to another type of accident other than auto; if YES, please explain.

15. WAS THE SERVICE PROVIDED IN NEBRASKA? Check the appropriate box to indicate if services were provided in Nebraska.

16. Please attach the following information which will allow the claim(s) to be reviewed without delay. With the claim form submit an itemized statement from your provider that includes the provider's complete address, dates of service, charges, procedures and diagnosis codes, Tax ID Number and NPI Number.

MAIL THE REQUIRED INFORMATION TO:

Blue Cross Blue Shield of Nebraska
P.O. Box 3248
Omaha, NE 68180-0001