BlueCross BlueShield of Vermont
An Independent Licensee of the Blue Cross and Blue Shield Association

BERLIN
445 INDUSTRIAL LANE
BERLIN, VERMONT 05602

P.O. BOX 186
MONTPELIER
VT 05601-0186

800 247 2583
800 255 4550

MEMBER CLAIM FORM – SUBMISSION INSTRUCTIONS

Read these submission instructions carefully and submit your completed form with all attachments.

We offer several convenient ways to submit your claim:

Preferred Method – Member Resource Center	**Alternate Methods**
Log into our secure member portal online at www.bluecrossvt.org/members to access your Secure Message Center! ✓ Click to send a "New Message" ✓ Click to "Add Recipient" and select the "Customer Service" department. ✓ Attach your claim form, invoice, and submission checklist and "Send."	**Mail**: Blue Cross Blue Shield of Vermont P.O. Box 186 Montpelier, VT 05601-0186 **Fax**: (866) 764-9653

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

IMPORTANT INFORMATION

- Submit a separate claim form for each member of the family who had services.
- Submit a separate claim form for each provider you saw.
- If your claim is for prescription drugs purchased at a pharmacy, you must submit your claim on a Prescription Reimbursement/Drug Claim Form directly to your Plan's pharmacy benefits manager.
- Keep a copy of your completed claim form and the itemized invoice for your own records.

If you have another primary insurance plan, such as Medicare, and you are submitting your claim to Blue Cross VT to consider balances left after your primary insurance, you must submit a copy of the primary carrier's explanation of benefits or a denial/opt-out letter.

Blue Cross VT issues payments for member-payable claims to the health plan benefits subscriber at the address on file. Travel reimbursement may be considered taxable income, so you should consult your tax advisor.

For reimbursement related to travel for restricted services, please read below and check if applicable.

☐ I reside in a state that bans and/or legislatively restricts access to abortion and/or gender affirming care.

TRACKING PROGRESS

To view the status of your claims, login to our secure Member Resource Center at bcbsvt.com/MRC. Please allow up to 10 business days after submission for your claim to appear online.

NEED HELP?

Use our Member Claim Form Submission Checklist to ensure that your claim is complete and ready for submission.

MEMBER CLAIM FORM (Page 2)

PATIENT INFORMATION

Patient's Name (Last, First)

Patient's Date of Birth
MO | DAY | YR

Blue Cross VT ID Number (from ID card)
Prefix (ex: ZID) | Number (ex: V812345678000)

Patient's Phone (including area code)
( )

Patient's Gender
☐ FEMALE ☐ MALE ☐ OTHER/NON-BINARY

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
MO | DAY | YR

Health Plan Group Number

Is this an employer-based health plan?
☐ YES ☐ NO

PROVIDER INFORMATION

Provider and Practice/Facility Name

Provider's Phone (including area code)
( )

Ordering or Referring Provider and State Located
Name | State

Provider's Address
Street:
City:
State: Zip:

Provider's ID Numbers
NPI
Tax ID
License Number | State Issued

ADDITIONAL INFORMATION

Was the condition related to the patient's employment?
☐ YES ☐ NO
If yes, include date of injury:
MO | DAY | YR

Was the condition related to an accident or injury involving another party?
☐ YES ☐ NO
If yes, include date of accident or injury:
MO | DAY | YR

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
					$		
					$		
					$		
					$		
					$		
					$		
				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. 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:_____