Excellus

Excellus BlueCross BlueShield
P.O. Box 21146
Eagan, MN 55121

MAIL THIS COMPLETED FORM TOGETHER WITH ALL ITEMIZED BILLS TO ADDRESS SHOWN ABOVE.

EXCELLUS MEDICARE ID#

THIS INFORMATION CAN BE TAKEN FROM YOUR ID CARD

MEMBER INFORMATION

MEMBER'S LAST NAME

MEMBER'S FIRST NAME

MEMBER'S STREET ADDRESS

CITY

STATE

ZIP

MEMBER DATE OF BIRTH ____ / ____ / _____ (MM / DD / YYYY)

SEX ☐ M ☐ F

ARE THE SUBMITTED EXPENSES RELATED, IN ANY WAY, TO A MOTOR VEHICLE OR WORK-RELATED ACCIDENT OR INJURY?

☐ Yes ☐ No

IF YES, DATE OF ACCIDENT OR INJURY

____ / ____ / _____ (MM / DD / YYYY)

DO YOU HAVE OTHER HEALTH INSURANCE? ☐ Y ☐ N

NAME OF OTHER INSURANCE

POLICY NUMBER

I certify that the above information is true, and the enclosed material is correct and unaltered, and the expenses were incurred by the patient. I understand all material submitted becomes the property of Excellus BlueCross BlueShield and will not be returned. I realize false receipt or fraudulent alterations of these materials will result in civil or criminal prosecution. I authorize the release of any information.

DATE	**PHONE** (including area code)	**SIGNATURE**

- Original itemized receipts including all pertinent information must be submitted with this claim form. The itemized bill must **clearly** indicate **all of the following:**
  - Patients full name and address on the letterhead of the provider of service or supply
  - Type of service or supply that was performed
  - Place of service (inpatient, outpatient, office, etc.)
  - Date and charge for each service or supply provided
  - Patient diagnosis (the medical condition for which the patient was treated)
  - For services not rendered in the USA, all information must be translated in English
- Cancelled checks, money orders, credit card vouchers and personal list of services or bills stating only "balance forward" are not acceptable.
- Make copies of the original receipts for your files before submitting the original. All materials submitted will be retained by us and cannot be returned to you.