

A nonprofit independent licensee of the  
BlueCross BlueShield Association

# Subscriber Claim Form



**Mail Completed Claims To: Excellus BlueCross BlueShield  
PO Box 22999  
Rochester, NY 14692**

Subscriber identification number (including ID prefix):

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Subscriber's  
Full Name

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Address

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City,  
State,  
Zip Code

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*If your address has changed or is incorrect, please call our Customer Service Department as instructed on the back of the form.*

## 1. Patient Information:

Patient's full name:

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Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Relationship to subscriber: <input type="checkbox"/> 1. Self <input type="checkbox"/> 3. Child <input type="checkbox"/> 2. Spouse <input type="checkbox"/> 4. College Student
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Patient's date of birth: 	If treatment was the result of a non-work injury, give date of injury: 
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If other than USA, in what country was patient treated?

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**Patient diagnosis** (illness/injury which required treatment):

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**2. Check if you want payment to be made directly to the provider . . .**   
(Nonparticipating providers are not eligible.)

## 3. Medicare:

Regardless of age, if the patient is covered by Medicare, please be sure to send bills and matching "Explanation of Medicare Benefit".

## 4. Motor Vehicle or Work Related Illness or Injury:

- a.** Was the treatment in any way motor vehicle related? . . . . .  YES  NO
- b.** Was the treatment the result of a work related illness or injury? . . . . .  YES  NO

<b>c.</b> If answer to a. or b. is yes, please describe accident or illness:	Date of accident or illness: 
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- Check If:**  I have other insurance.  
 My other insurance has changed.

## 5. Other Insurance Carrier:

If the patient is covered by another health care plan:

**If we are your secondary insurance, please be sure to send itemized bill and matching Explanation of Benefit form(s) from the other insurance company.**

Policyholder's name:	Date of birth:	Social Security number:	Relationship to patient:
Name of policyholder's employer:			Employment status: <input type="checkbox"/> Active <input type="checkbox"/> Retired
Name and address of insurance carrier:		This policy covers the: <input type="checkbox"/> Individual <input type="checkbox"/> Husband & Wife <input type="checkbox"/> Family <input type="checkbox"/> Parent & Child	
Policy or certificate number:	Effective/Cancellation date:	Carrier's telephone number:	Spouse's date of birth:

## 6. Claim Date and Subscriber Signature: (Unsigned claims will be returned.)

Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information, or conceals information concerning any fact material thereto, for the purpose of misleading, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed \$5,000 and the stated value of the claim for each violation. In addition, I hereby authorize any insurance company, organization, employer, hospital, doctor or any other provider of service to release any information requested relevant to this claim and any attached bills.

Date: | | | Subscriber's signature: \_\_\_\_\_

