Blue Cross Blue Shield of Michigan

A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

Member Reimbursement

I paid out of pocket and I am requesting reimbursement for medical services.

Usually, we pay your health care providers for you without you having to do anything. But, sometimes you have to pay the doctor or hospital yourself. This form is how you ask us to reimburse you.

Please fully complete the form, print clearly

Clear Form

Section 1 — Member information

From your Blue Cross Blue Shield of Michigan member ID card	Subscriber's alpha-numeric contract number		Blue Cross group number
	Alpha:	Numeric:	

Subscribers last name	Subscribers first name

Subscriber's street address		
City	**State**	**ZIP**

Section 2 — Patient information

Patient's first name	Sex	Medicare HIB / MBI number
	M ○ F ○	

Patient's date of birth	Date of illness or injury	Admission date	Discharge date

Was this related to: Check box that applies	This was related to:	Other health insurance
Auto Accident Work Related ☐	Other:	Yes ○ No ○
Metabolic Diseases & Foods ☐		
Accidental Dental ☐	_____	

Section 3 — Other insurance information

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 Blue Cross Blue Shield of Michigan 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 necessary to process or review this claim.

Sign after printing.

X_____ _____

Signature Date

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How to submit your reimbursement form	Questions
Fax to **: 1-844-318-5146** **Or** Mail to: **Blue Cross Blue Shield of Michigan** **Member Reimbursement – Mail Code: 0010** **600 E. Lafayette Blvd.** **Detroit, MI 48226** **Keep a copy of all documents you send us. Allow 30 days for processing.**	Call Customer Service at the number on the back of your Blue Cross member ID card.

Reminder! **Massage Therapy** Claims should be sent directly to the following:

Fax: 844-318-5146 Attn: WMU Claims

Mail:
Attn: WMU Claims
Blue Cross Blue Shield of MI
PO Box 230555
Grand Rapids, MI 49523-0555

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Send the provider's statement and a copy of your paid receipt (if paid using personal check, please provide copies of the front and back of the check) with this form by U.S. mail or fax. Make sure the statement shows the patient's name, date of service, diagnosis code (a code that describes the condition), procedure code (a code that describes what service your provider is billing for), the amount charged for each service performed and proof of payment. If you have questions, please call Customer Service.

To speed up our processing remember to:

- Fill out a separate form for each claim.
- Mail only original receipts, including all pertinent information on provider's letterhead. Without this information, your claim will be returned to you. Cash register receipts, canceled checks, money orders and personal itemizations cannot be used in benefit payment consideration.
- Make copies of the original receipts for your files before sending us the original. We will keep all materials in our files and they cannot be returned to you.
- If the patient has Medicare coverage, fill in the Medicare number including alpha characters. Be sure you include the *Medicare Summary Notice* that was sent explaining the charges paid or not paid by Medicare. This is not required for dental, vision or hearing services.

If another health care plan has already paid a portion of the service, attach a copy of the explanation of benefits you received from that other plan.