WYOMING
An independent licensee of the Blue Cross and Blue Shield Association

4000 House Avenue ** P O Box 2266
Cheyenne, WY 82003-2266

MEDICAL CLAIM FORM

(Instructions for filing on second page)

PARTICIPANT'S NAME *(Last, First, M.I.)*		ALPHA PREFIX and BCBS ID NUMBER	
HOME ADDRESS *(Street, City, State, Zip)*		IS THIS A NEW ADDRESS? ☐ Yes ☐ No	
PATIENT'S NAME *(Last, First, M.I.)*	☐ MALE ☐ FEMALE	DATE OF BIRTH *(MM/DD/YYYY)*	RELATIONSHIP TO PARTICIPANT ☐ Self ☐ Spouse ☐ Child

DESCRIBE THE ILLNESS, INJURY OR SYMPTOMS REQUIRING TREATMENT:

IF ILLNESS OR INJURY RESULTED FROM AN ACCIDENT, WAS IT DUE TO:	INDICATE DATE OF ACCIDENT *(MM/DD/YYYY)*
AUTO ☐ EMPLOYMENT ☐ OTHER ☐ (*Briefly Describe*) _____	

OTHER HEALTH INSURANCE: *Is the patient covered by additional health insurance through an employer, a group such as a professional organization or any other group health insurance, including other Blue Cross and/or Blue Shield coverage?* ☐ YES ☐ NO *If yes, please complete this section.*		
NAME AND ADDRESS OF INSURING COMPANY *(Street, City, State, Zip)*	EFFECTIVE DATE *(MM/DD/YYYY)*	TERMINATION DATE *(MM/DD/YYYY)*
NAME OF POLICYHOLDER *(Last, First, M.I.)*	DATE OF BIRTH *(MM/DD/YYYY)*	IDENTIFICATION NUMBER *(Including all letters & numbers)*

I CERTIFY THAT THE ABOVE IS CORRECT AND COMPLETE AND THAT I AM CLAIMING BENEFITS ONLY FOR THE CHARGES INCURRED BY THE PATIENT NAMED ABOVE.

Signature of Participant _____ Date _____

INSTRUCTIONS FOR FILING CLAIMS

1. A separate claim form must be submitted for each family member.

2. Itemized bills for covered services, supplies and durable medical equipment **MUST** be attached and show:

   A. Name of patient and date of birth
   B. Date of service and charge for each
   C. Type of services/supplies/equipment received (surgery, office calls, crutches, etc.)
   D. Description of illness or accident
   E. Date of accident

3. Bills for prescription medication must include above information as well as:

   A. Patient's Name
   B. Description of Illness or Accident
   C. Name of Drug
   D. Name of Pharmacy
   E. Prescribing Physician
   F. Date Purchased and Charge for Each Drug
   G. If actual drug receipt is not available, pharmacist signature is required

4. Questions on filing medical claims should be directed to:

   Member Services Center
   Blue Cross Blue Shield of Wyoming
   P O Box 2266
   Cheyenne, WY 82003-2266
   307.634.1393
   1.800.442.2376

NOTE: ***Balance*** *due statements, cash register receipts, cancelled checks and cash receipts* ***are not*** *acceptable.*

ITEMIZED BILLS CANNOT BE RETURNED

SAMPLE OF BCBS IDENTIFICATION CARD