Member Claim Form Requirements

Please note the below filing requirements and tips for filling out the attached Member Claim Form. Do not file prescription drugs or dental claims with this form.

Visit **shpnc.org/employee-benefits/important-forms** for prescription drug and international claim forms, or call the toll-free number on your ID card.

Important Notes When Completing the Claim Form:

- Type or use blue or black ink to complete
- Complete a separate claim form for each covered family member
- Complete a separate claim form for each provider
- Attached receipts must include procedure codes and diagnosis codes (such as CPT/Dx codes), individual cost for each service, and the provider's name, address and Tax ID
- Do not file a claim if the provider is filing for the same services or if the provider is in-network
- Attach Explanation of Benefits if these services are covered by another insurance policy
- Claims must be filed within 18 months from the date services were received, or they will be denied
- If your address has recently changed, please contact Customer Service using the phone number located on the back of your ID card to ensure our records are accurate
- Keep a copy of this form and your receipts
- Remember to sign and date at the bottom of Section 5

Please note: Claim form will be returned to member if provider receipts are not attached with the form!

Blue Cross and Blue Shield of North Carolina and the North Carolina State Health Plan are not affiliated.

Member Claim Form

SECTION 1: Patient Information

Please enter the subscriber number from your ID card.

Subscriber Number: Begin with Letter Prefix ☐☐☐☐☐☐☐☐☐☐☐☐ – ☐☐ **2 Digits Following Member's Name** (see ID card)

Patient's Last Name: ______ First Name: ______ Middle Initial: ______

Date of Birth: ☐☐ – ☐☐ – ☐☐☐☐

Sex: ☐ Male ☐ Female

Relationship to Subscriber: ☐ Self ☐ Child ☐ Spouse ☐ Other: ______

SECTION 2: Mailing Information

Subscriber Name: ______

Address (Line 1): ______

City: ______ State: ☐☐ Zip Code: ☐☐☐☐☐ – ☐☐☐☐

SECTION 3: Other Insurance Information

Please complete the information below if the patient is covered by another health insurance policy.

Does the Patient have Other Insurance? ☐ Yes ☐ No

Other Health Insurance Company Name: ______

Other Policy Number: ______

Other Policy holder's Name: ______

Other Policy Holder's Employer Name: ______

Please complete the information below if the patient is covered by Medicare:

Medicare Health Insurance Claim Number: ______

Is Patient Eligible for: (check all that apply) ☐ Part A ☐ Part B ☐ Part C

SECTION 4: International Information

Please complete the information below if the provider or services rendered were out of the United States.

Country: ______ **Currency Used:** ______

SECTION 5: Submitting Form Information

MAIL THIS FORM, ITEMIZED RECEIPTS AND EXPLANATION OF BENEFITS (if applicable) TO:

Blue Cross and Blue Shield of North Carolina
P.O. Box 30087
Durham, NC 27702
FAX: 1-866-990-1385

FOR ALL PRESCRIPTION DRUGS OR INSULIN THAT ARE NOT BEING FILED BY YOUR PROVIDER, PLEASE COMPLETE A PRESCRIPTION DRUG CLAIM FORM AND MAIL TO:

CVS Caremark
P.O. Box 52136
Phoenix, Arizona 85072-2136

PLEASE NOTE: If your other insurance or Medicare policy is primary, you must attach a copy of the Explanation of Benefits from that insurer. Your claim cannot be processed without this information.

I certify that the information on this form is correct and the expenses incurred were necessary for the services filed.

Signature: ______ Date: ______ Daytime Phone Number: ______

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North Carolina State Health Plan FOR TEACHERS AND STATE EMPLOYEES
A Division of the Department of State Treasurer

State Treasurer of North Carolina Dale R. Folwell, CPA

BlueCross BlueShield of North Carolina