Blue Cross Blue Shield of Michigan

SUBSCRIBER APPLICATION FOR PAYMENT

DIRECT TO BLUE CROSS BLUE SHIELD OF MICHIGAN FOR PAYMENT. IF YOUR SERVICES WERE RENDERED BY A MICHIGAN PROVIDER, HE/SHE MAY BILL THESE CLAIM BENEFITS.

Mail your claims to: Blue Cross and Blue Shield of Michigan
600 Lafayette East, B321
Detroit, MI 48226-2998

1. SUBSCRIBER'S LAST NAME	2. SUBSCRIBER'S FIRST NAME

3. SUBSCRIBER'S STREET ADDRESS — 4. GROUP NUMBER

5. CITY — 6. STATE — 7. ZIP CODE

8. SUBSCRIBER I.D. NUMBER — 9. PATIENT'S FIRST NAME — 10. SEX ☐ M ☐ F — 11. DATE OF BIRTH MO. DAY YR. — 12. RELATIONSHIP CODE ☐ SELF ☐ SPOUSE ☐ DEPENDENT

13. OTHER INSURANCE PAID THIS CLAIM? ☐ NO ☐ YES — 14. POLICY HOLDER — 15. POLICY NUMBER — 16. OTHER INSURANCE COMPANY NAME AND ADDRESS

17. WORKMAN'S COMP. ☐ NO ☐ YES — 18. MEDICARE HIB NUMBER — 19. DATE OF INJ/ILL/LMP MO. DAY YR. — 20. AUTO ACCIDENT ☐ NO ☐ YES — 21. ADMISSION DATE MO. DAY YR. — 22. DISCHARGE DATE MO. DAY YR.

I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND THE ATTACHED MATERIAL IS CORRECT AND UNALTERED AND THAT THE EXPENSES WERE INCURRED BY THE ABOVE NAMED PATIENT. I UNDERSTAND THAT ALL MATERIAL SUBMITTED BECOMES THE PROPERTY BLUE CROSS AND BLUE SHIELD OF MICHIGAN AND MAY NOT BE RETURNED. I REALIZE FALSE RECEIPTS 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.

SIGNATURE — DATE — AREA CODE — TELEPHONE NUMBER

PROVIDER INFORMATION

PROVIDER NAME — PROVIDER ADDRESS LINE 1

PROVIDER ADDRESS LINE 2

CITY — STATE — ZIP CODE — PROVIDER TAX I.D.

FOR BLUE CROSS AND BLUE SHIELD USE ONLY. DO NOT WRITE IN SPACES BELOW

CLAIMS RECEIPT DATE	PROVIDER CODE	ATTACH COUNT	PREPARED BY	PRIOR AUTHORIZATION NUMBER	PROGRAM ☐ O/S ☐ FOR ☐ COMP

	DATE OF SERVICE	DATE OF SV (TO)	LOC	TYPE	SERIAL	CP	APPROVED AMOUNT	AMOUNT CHARGED	DX CODE	QUANTITY
1										
D OF N	MISC. DATE	M-1	M-2	M-3	WHY	PROVIDER CODE		MEDICARE REASONABLE	MEDICARE DEDUCTIBLE	

	DATE OF SERVICE	DATE OF SV (TO)	LOC	TYPE	SERIAL	CP	APPROVED AMOUNT	AMOUNT CHARGED	DX CODE	QUANTITY
2										
D OF N	MISC. DATE	M-1	M-2	M-3	WHY	PROVIDER CODE		MEDICARE REASONABLE	MEDICARE DEDUCTIBLE	

	DATE OF SERVICE	DATE OF SV (TO)	LOC	TYPE	SERIAL	CP	APPROVED AMOUNT	AMOUNT CHARGED	DX CODE	QUANTITY
3										
D OF N	MISC. DATE	M-1	M-2	M-3	WHY	PROVIDER CODE		MEDICARE REASONABLE	MEDICARE DEDUCTIBLE	

	DATE OF SERVICE	DATE OF SV (TO)	LOC	TYPE	SERIAL	CP	APPROVED AMOUNT	AMOUNT CHARGED	DX CODE	QUANTITY
4										
D OF N	MISC. DATE	M-1	M-2	M-3	WHY	PROVIDER CODE		MEDICARE REASONABLE	MEDICARE DEDUCTIBLE	

	DATE OF SERVICE	DATE OF SV (TO)	LOC	TYPE	SERIAL	CP	APPROVED AMOUNT	AMOUNT CHARGED	DX CODE	QUANTITY
5										
D OF N	MISC. DATE	M-1	M-2	M-3	WHY	PROVIDER CODE		MEDICARE REASONABLE	MEDICARE DEDUCTIBLE	

	DATE OF SERVICE	DATE OF SV (TO)	LOC	TYPE	SERIAL	CP	APPROVED AMOUNT	AMOUNT CHARGED	DX CODE	QUANTITY
6										
D OF N	MISC. DATE	M-1	M-2	M-3	WHY	PROVIDER CODE		SUBEDICARE REASONABLE	MEDICARE DEDUCTIBLE	

DOCUMENT NUMBER - DO NOT WRITE IN THIS AREA

YOUR RIGHT TO CONFIDENTIALITY

WE WILL NOT RELEASE ANY INFORMATION ABOUT YOU EXCEPT: 1) WHEN YOU ASK US TO IN WRITING, OR 2) WHEN RELEASE (TO ANOTHER INSURANCE COMPANY FOR EXAMPLE) IS NECESSARY TO PROCESS OR REVIEW A CLAIM. WE WILL TELL YOU WHICH INFORMATION WE RELEASED TO WHOM, IF YOU REQUEST IT.

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