Regence

DIRECT MEMBER REIMBURSEMENT FORM

Regence BlueCross BlueShield of Oregon is an Independent Licensee of the Blue Cross and Blue Shield Association

Thank you for choosing Regence BlueCross BlueShield of Oregon for your health insurance coverage. Use this claim form for any reimbursement requests you may have or if you prefer, send a copy of your bill with your Group and ID Numbers written at the top and mail to the address below. For prescription, supplies or medical equipment requests, please complete a "Prescription & Durable Medical Equipment Claim Form" (PD001). If you received services from a participating provider, your claim should be submitted by the provider; therefore, you do not need to submit this form unless you know that your claim was not submitted. Please complete a separate form for each family member or provider (print additional copies of page 2 if necessary). **For claim filing time limits, review your benefit information.**

1. Complete the information below and where indicated on the following pages for each receipt submitted.
2. Write your ID number on the top of each page.
3. Tape your original prescription receipts in the boxes marked for receipts; cash register receipts will not be accepted.
4. Retain copies of receipts for your records. Receipts will not be returned.
5. Sign the completed form where indicated at the bottom of this page and mail to:
   Regence BlueCross BlueShield of Oregon
   PO Box 1271 MS C7A
   Portland, OR 97207-1271
6. This form is to be used **only** for services in Oregon and Clark County, WA. For services outside this area, please contact customer service directly at 1 (800) 365-3155 as your claim will require special handling.

Identification Number (3 letters followed by 9 numbers)				
Patient's Last Name	Patient's First Name			MI
Patient's Date of Birth	Patient's Sex: ☐ Male ☐ Female	Patient's Relationship to Subscriber: ☐ Self ☐ Spouse or OR certified domestic partner (DP) ☐ Dependent		Daytime Phone Number
Subscriber's Last Name	Subscriber's First Name			MI
Subscriber's Address	City		State	ZIP Code
Group Name	Group Number			

OTHER INSURANCE INFORMATION

Are you or ANY family members on this policy covered by other

Medical coverage? ☐ Yes ☐ No Vision Coverage? ☐ Yes ☐ No

Dental coverage? ☐ Yes ☐ No With Orthodontia? ☐ Yes ☐ No

Prescription Coverage? ☐ Yes ☐ No

If YES, is this coverage ☐ Group ☐ Individual

Are you or any family members covered by Medicare? ☐ Yes ☐ No (If YES: Part A Part B Part D)

IF THE ANSWER TO ANY OF THE ABOVE QUESTIONS IS "YES," please complete the section(s) below.

If you have more than one additional policy, attach information on a separate sheet of paper.

Name of Other Group Insurance Plan	Subscriber's Name	ID Number	Relationship to Subscriber	Date of Birth
Address for Submitting Claims	City	State	ZIP Code	
This Coverage is For: Subscriber Spouse/DP Child(ren)	If two or more coverage's are available for children of divorced parents, indicate name of person with legal custody.	Numbers that identify you to other group (ID numbers, etc.)		
Subscriber's Employer	☐ Active ☐ Retiree	Effective Date of this Plan		

If paid in cash, please indicate why _____

I certify that the above statements are correct and hereby authorize any physician, hospital, employer, union, insurance company, or prepayment organization to supply my employer and its agents any information required in connection with this claim. A photocopy of this authorization shall be as valid as the original.

Signature (Subscriber or Patient) _____ Date _____

ID Number _____

Medical, Dental and Vision receipts must contain:
Provider's Name and Address
Diagnosis and Procedure Codes
Itemized Charges

Contact the provider if you need additional information.

TAPE RECEIPT HERE
In date order

_____
Nature of Illness/Injury

_____
Doctor's Name (If not on receipt)

_____
If Injury, Date Occurred

_____
How, When, Where

TAPE RECEIPT HERE
In date order

_____
Nature of Illness/Injury

_____
Doctor's Name (If not on receipt)

_____
If Injury, Date Occurred

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