MASSACHUSETTS

Medex® Subscriber Claim Form

Please read the instructions and print clearly in the required boxes.

Note: This should not be used to submit a drug claim if you are a direct-pay member. Instead, fill out a separate Medex Drug Claim Form.

For services rendered OUTSIDE OF THE U.S, visit **bcbsglobalcore.com**.

Medex Identification Number
(including alpha prefix)

Important: This can be found on your Medex ID card.

Instructions

- Submit a claim only when you are billed for services from a provider that does not directly submit a claim to the local Blue Cross Blue Shield plan.
- Use reverse side or another sheet of paper to include any additional information, if necessary.
- Please include proof of payment and itemized bill from provider.
- Please submit all receipts on an 8 x 11 sheet of paper.
- Keep a copy of all bills and claim forms submitted (originals will not be returned).
- Be sure to sign and date the completed form.

Please send claim form and all attachments to:

Blue Cross Blue Shield of Massachusetts
P.O. Box 986030
Boston, MA 02298
Fax: 617-246-8953

Part I

First Name	Last Name	Middle Initial	Suffix

Street Address

City _____ State _____ ZIP _____

Your gender	Your complete date of birth: (MM/DD/YY)	Medicare Number
☐ Male ☐ Female		

See Reverse: Please Date and Sign Your Name in the Space Provided

Part II

Total Number of Bills Attached: _____ Total Charges: $ _____

Claim Checklist

Please review this checklist before sending your claim to us. Incomplete forms may be returned to you.

- ☐ Have you listed your Medex Identification Number in the space provided?
- ☐ Have you attached all related Explanation of Benefits (EOB) or Health Plan Summary of Benefits forms you may have received previously for these services?
- ☐ Have you signed and dated the completed claim(s) form?
- ☐ Have you kept a copy of all receipts and EOB's?

Certification and Authorization

I authorize the release of any information to Blue Cross and Blue Shield about my examination and treatment. I certify that the information provided in the support of this claim is complete and correct and that I have not been previously reimbursed for these services.

Member's Signature _____ Date _____

Blue Cross Blue Shield of Massachusetts complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity.

ATTENTION: If you don't speak English, language assistance services, free of charge, are available to you. Call Member Service at the number on your ID card (TTY: **711**).

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia con el idioma. Llame al número de Servicio al Cliente que figura en su tarjeta de identificación (TTY: **711**).

ATENÇÃO: Se fala português, são-lhe disponibilizados gratuitamente serviços de assistência de idiomas. Telefone para os Serviços aos Membros, através do número no seu cartão ID (TTY: **711**).

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