


**MAIL THIS COMPLETED FORM TOGETHER WITH ALL ITEMIZED BILLS TO ADDRESS SHOWN ABOVE.**

<b>EXCELLUS MEDICARE ID#</b>		<b>THIS INFORMATION CAN BE TAKEN FROM YOUR ID CARD</b>
<input style="width: 90%;" type="text"/>		
<b>MEMBER INFORMATION</b>		
<b>MEMBER'S LAST NAME</b>	<b>MEMBER'S FIRST NAME</b>	
<input style="width: 90%;" type="text"/>	<input style="width: 90%;" type="text"/>	
<b>MEMBER'S STREET ADDRESS</b>		
<input style="width: 95%;" type="text"/>		
<b>CITY</b>	<b>STATE</b>	<b>ZIP</b>
<input style="width: 60%;" type="text"/>	<input style="width: 15%;" type="text"/>	<input style="width: 20%;" type="text"/>
<b>MEMBER DATE OF BIRTH</b>	<b>SEX</b> <input type="checkbox"/> M <input type="checkbox"/> F	
_____ / _____ / _____ MM DD YYYY		
<b>ARE THE SUBMITTED EXPENSES RELATED, IN ANY WAY, TO A MOTOR VEHICLE OR WORK-RELATED ACCIDENT OR INJURY?</b>	<b>IF YES, DATE OF ACCIDENT OR INJURY</b>	
<input type="checkbox"/> Yes <input type="checkbox"/> No	_____ / _____ / _____ MM DD YYYY	
<b>DO YOU HAVE OTHER HEALTH INSURANCE?</b> <input type="checkbox"/> Y <input type="checkbox"/> N		
<b>NAME OF OTHER INSURANCE</b>	<b>POLICY NUMBER</b>	
<input style="width: 90%;" type="text"/>	<input style="width: 90%;" type="text"/>	

I certify that the above information is true, and the enclosed material is correct and unaltered, and the expenses were incurred by the patient. I understand all material submitted becomes the property of Excellus BlueCross BlueShield and will not be returned. I realize false receipt or fraudulent alterations of these materials will result in civil or criminal prosecution. I authorize the release of any information.

<b>DATE</b>	<b>PHONE</b> (including area code)	<b>SIGNATURE</b>
<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>

- Original itemized receipts including all pertinent information must be submitted with this claim form. The itemized bill must **clearly** indicate **all of the following**:
  - Patients full name and address on the letterhead of the provider of service or supply
  - Type of service or supply that was performed
  - Place of service (inpatient, outpatient, office, etc.)
  - Date and charge for each service or supply provided
  - Patient diagnosis (the medical condition for which the patient was treated)
  - For services not rendered in the USA, all information must be translated in English
- Cancelled checks, money orders, credit card vouchers and personal list of services or bills stating only "balance forward" are not acceptable.
- Make copies of the original receipts for your files before submitting the original. All materials submitted will be retained by us and cannot be returned to you.