BlueCross BlueShield of Vermont
An Independent Licensee of the Blue Cross and Blue Shield Association

BERLIN
445 INDUSTRIAL LANE
BERLIN, VERMONT 05602

P.O. BOX 186
MONTPELIER
VT 05601-0186

800 247 2583
800 922 8778
800 255 4550

MEMBER CLAIM FORM

To complete the form, please follow these instructions carefully and email your receipt to customerservice@bcbsvt.com.

- Add your personal information, ID number, group number, and employer-based health plan status.
- Fill in the date of service/purchase and the amount (page 2 below).
- You can skip the boxes for Physicians and Additional information.
- Type your name on the signature line and include the date signed.
- Email the completed form and your itemized receipt to our customer service team at customerservice@bcbsvt.com. We can't process your claim without an itemized invoice.

You must submit a separate claim form for the prenatal educational class and the enhanced benefit that you chose with your Better Beginnings nurse during your initial call. If you would like to change the maternal health benefits you've selected, please contact your Better Beginnings nurse before sending us any of the above forms.

You will receive your reimbursement check in about four to six weeks.

PATIENT INFORMATION

Patient's Name (Last, First)	**Patient's Date of Birth** (MO | DAY | YR)	**BCBSVT ID Number** from ID card Prefix (ex: ZII) | Number (ex: V812345678000)
Patient's Phone including area code	**Patient's Gender** ☐ MALE ☐ FEMALE	**Patient's Address** Street: City: State: | Zip:
Health Plan Subscriber's Name (Last, First)	**Patient's Relationship to Subscriber** ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER	
Health Plan Subscriber's Date of Birth	**Health Plan Group Number**	**Is this an employer-based health plan?** ☐ YES ☐ NO

PROVIDER INFORMATION

Provider and Practice/Facility Name	Provider's Address Street: City: State: | Zip:	Provider's ID Numbers NPI Tax ID License Number | State Issued
Provider's Phone including area code		
Ordering or Referring Provider and State Located Name | State		

ADDITIONAL INFORMATION

Was the condition related to the patient's employment? ☐ ES ☐ NO If yes, include date of injury:	Was the condition related to an accident or injury involving another party? ☐ YES ☐ NO If yes, include date of accident or injury:	Other insurance company name and phone number Name: Phone including area code

CLAIM INFORMATION (Please work with your provider to fill in the shaded areas.)							
Date of service (MO DAY YR)	Description of Service	Procedure Code	Modifier	Diagnosis Code	Charge	Units	POS
	Homemaker Services	BB3		Z39.2	$		**12**
	hours/day _____ amt/hour $_____				$		
	hours/day _____ amt/hour $_____				$		
	hours/day _____ amt/hour $_____				$		
	hours/day _____ amt/hour $_____				$		
	hours/day _____ amt/hour $_____				$		
				Total Bill:	$		

I authorize any hospital, physician or other provider to release to Blue Cross and Blue Shield of Vermont any information deemed necessary to process my claim for benefits. 1250.01: The person signing this form understands that the willful making of a false or fraudulent statement herein renders him/her liable to prosecution.

Signature of Member or Subscriber: _____ Date signed: _____

Disclaimers

General Exclusions

While your health plan covers a broad array of necessary services and supplies, it doesn't cover every possible medical expense. If you would like to review the list of general exclusions before enrolling, visit **bluecrossvt.org/contracts**, click on the plan in which you are enrolling and read the chapter entitled "General Exclusions." Once you enroll, you will receive an Outline of Coverage and a link to your Certificate of Coverage. Please read both carefully as they govern your specific benefits.

How We Protect Your Privacy

The law requires us to maintain the privacy of your health information by using or disclosing it only with your authorization or as otherwise allowed by law. You may find information about our privacy practices at **bluecrossvt.org/privacypolicies**.

NOTICE: Discrimination is Against the Law

BlueCross and BlueShield of Vermont (Blue Cross) and its affiliate The Vermont Health Plan (TVHP) comply with applicable federal and state civil rights laws and do not discriminate, exclude people or treat them differently on the basis of race, color, national origin, age, disability, gender identity or sex, ethnicity, sexual orientation, or HIV-status.

Blue Cross provides free aids and services to people with disabilities to communicate effectively with us. We provide, for example, qualified sign language interpreters and written information in other formats (e.g., large print, audio or accessible electronic format).

Blue Cross provides free language services to people whose primary language is not English. We provide, for example, qualified interpreters and information written in other languages.

If you need these services, **contact civilrightscoordinator@bcbsvt.com**

If you believe that Blue Cross has failed to provide these services or discriminated in another way based on race, color, national origin, age, disability, gender identity or sex, ethnicity, sexual orientation, or HIV-Status, you can file a grievance with: Kienan D. Christianson, Civil Rights Coordinator, P.O. Box 186, Montpelier, VT 05601-0186, call (800) 247-2583, fax (802) 229-0511, or email **civilrightscoordinator@bcbsvt.com**. You can file a grievance in person, by mail, via fax, or by email. If you need help filing a grievance, Kienan D. Christianson, Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically or through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW Room 509F,
HHH Building Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**

For free language-assistance services, call (800) 247-2583.

ARABIC	للحصول على خدمات المساعدة اللغوية المجانية ، اتصل (800) 247 2583. lilhusul ealaa khadmat almusaeadat allughawiat almajaaniat, atasal (800) 247-2583.
CHINESE	如需免费语言协助服务，请致电, (800) 247-2583. Rú xū miǎnfèi yǔyán xiézhù fúwù, qǐng zhìdiàn (800) 247-2583.
CUSHITE (OROMO)	Tajaajila gargaarsa afaanii bilisaa argachuuf, (800) 247-2583 bilbili.
FRENCH	Pour des services d'assistance linguistique gratuits, appelez le (800) 247-2583.
GERMAN	Für kostenlose Sprachunterstützungsdienste rufen Sie (800) 247-2583 an.
ITALIAN	Per i servizi di assistenza linguistica gratuiti, chiamare il numero (800) 247-2583.
JAPANESE	無料の言語支援サービスについては, (800) 247-2583. Muryō no gengo shien sābisu ni tsuite wa ,(800) 247-2583 made o denwa kudasai.
NEPALI	निःशुल्क भाषा-सहायता सेवाहरूको लागि, कल गर्नुहोस् , (800) 247-2583. Niḥśulka bhāṣā-sahāyatā sēvāharūkō lāgi, kala garnuhōs (800) 247-2583.
PORTUGUESE	Para serviços gratuitos de assistência linguística, ligue para (800) 247-2583.
RUSSIAN	Чтобы получить бесплатную языковую помощь, позвоните по телефону (800) 247-2583.
SERBO-CROATIAN (SERBIAN)	За бесплатне услуге језичке помоћи позовите (800) 247-2583. Za besplatne usluge jezičke pomoći pozovite (800) 247-2583.
SPANISH	Para servicios gratuitos de asistencia lingüística, llame al (800) 247-2583.
TAGALOG	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa (800) 247-2583.
THAI	สำหรับบริการช่วยเหลือด้านภาษา ฟรี โทร,(800) 247-2583. S̄āh̄rạb brikār chwyh̄elūx d̄ān phās̄'ā frī thor (800) 247-2583.
UKRAINIAN	Щоб отримати безкоштовні мовні послуги, телефонуйте (800) 247-2583. Shchob otrymaty bezkoshtovni movni posluhy, telefonuyte (800) 247-2583
VIETNAMESE	Đối với các dịch vụ hỗ trợ ngôn ngữ miễn phí, hãy gọi (800) 247-2583.