Blue Cross Blue Shield Out of Network Services:
Please Call CBA Blue Customer Service
888-222-9206 Monday-Friday 8am-7pm EST
A Representative Can Provide You With the Correct Address For Submitting Claims

CBA Blue

Blue Card Medical Claim Form
Home Plan Code 422/922
Claim Form For Out Of Network Services

Employee Information		
1. Last Name	2. First Name	3. Mid
4. Street Address:		4a. Apt./Unit #
5. Birth Date: / / (month / day / year)		
6. City:	7. State:	8. Zip:
9. Group Number (from your ID Card):		
10. Member Identification Number (from your ID Card):		

Patient Information		
11. Last Name:	12. First Name:	13. Mid:
14. Street Address:		14a. Apt./Unit #
15. City:	16. State:	17. Zip:
18. Birth Date: / / (month / day / year)		

Claim Information	
19. Is this claim the result of an accidental injury? 0 No 0 Yes If "Yes" , please complete below:	
19a. Injury Date: / / (month / day / year)	19b. Where accident occurred and details:
20. Was the injury in any way work related? 0 No 0 Yes	
21. Date of Service(s):	
22. Provider(s) of Service:	
23. Reimbursement should be provided to: 0 Member 0 Provider of Service *If you paid upfront for services, please include a receipt confirming payment.	

I certify that the above is complete and correct and that I am claiming benefits only for charges incurred by the patient above. Authorization is hereby given to any hospital, physician, or other provider which participated in any way in my care and treatment to release to CBA Blue any medical information which they in their judgment deem necessary to the adjudication of this claim.

Participant Signature **Date**

_____ _____

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Medical Claim Form Instructions

Employee Information:

1. Last Name
2. First Name
3. Middle Initial
4. Street Address (Mailing Address) 4a. Apartment or Unit Number
5. Birth Date
6. City
7. State
8. Zip
9. Group Number (five digit number from your ID card)
10. Member Identification Number (include the three leading alpha character and nine digit suff**ix)**

Patient Information (if you are submitting claims for more than one patient, use multiple forms):

11. Patient's Last Name
12. Patient's First Name
13. Patient's Middle Initial
14. Patient's Street Address (if different from Employee) 14a. Apartment or Unit Number
15. Patient's City (if different from Employee)
16. Patient's State (if different from Employee)
17. Patient's Zip (if different from Employee)
18. Patient's Date of Birth

Claim Information:

19. Indicate if claim was the result of an accidental injury, check yes or no 29a. & 29b. Date/Details Injury
20. If Injury, indicate if work related
21. Date(s) Of Service of Claim(s) being submitted for reimbursement
22. Provider(s) of Service for claims being submitted
23. Indicate where reimbursement should be sent. Include a receipt confirming if the claim was paid up front.

Please contact Customer Service for the correct address to submit this claim to. Sign the form and remit to the address provided. Please include an itemized bill(s) from the provider(s) of service. Claims filed for prescription reimbursement should include the pharmacy receipt (not cash register receipt). Attach prescriptions to a separate piece of paper.

CBA Blue, 46 Bowdoin St., South Burlington, VT 05403 | 888-222-9206