



## DIRECT MEMBER REIMBURSEMENT FORM

Thank you for choosing us for your health insurance coverage. Use this claim form for any reimbursement requests you may have. 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, pharmacy, or provider (print additional copies of Pg. 2 if necessary). **For claim filing time limits, review your benefit information.**

1. Complete the information below and where indicated on the following page.
2. Write your ID number on the top of each page.
3. Tape your original 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 BlueShield of Idaho  
P.O. Box 1106  
Lewiston, ID 83501-1106

MEMBER INFORMATION		
Patient's Name (Last, First, M.I.)	Patient's Date of Birth	Patient's Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
Policyholder's Name (Last, First, M.I.)	Patient's Relationship to Policyholder <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependant	
Policyholder's Address (Street, City, State & Zip)		Telephone Number
Policyholder's ID Number (3 letters followed by 9 numbers)	Group Name	Group Number
OTHER INSURANCE INFORMATION		
Are you or ANY family member on this policy covered by other:		
Medical coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	Vision coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Dental coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	With Orthodontia? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Prescription coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If Yes: <input type="checkbox"/> Group <input type="checkbox"/> Individual		
Are you or any family members covered by Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If Yes: <input type="checkbox"/> Part A <input type="checkbox"/> Part B <input type="checkbox"/> Part D		
IF THE ANSWER TO ANY OF THE ABOVE QUESTIONS IS "YES", please complete this section regarding the other insurance. If there are more than 1 additional policies, attach the requested information for each policy on a separate sheet of paper.		
Name of Other Insurance	Subscriber's Name, ID# & Birth Date	Subscriber's Relationship to Regence Policyholder
Address for Submitting Claims		
This Other Insurance Covers: <input type="checkbox"/> Regence Policyholder's Spouse <input type="checkbox"/> Regence Policyholder <input type="checkbox"/> Dependents		If covered children are from divorced parents, indicate name of person with legal custody:
Name of Subscriber's Employer	<input type="checkbox"/> Active <input type="checkbox"/> Retiree	Effective date of this plan

Please indicate why the patient paid cash: \_\_\_\_\_

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.

Signed (Subscriber or Patient): \_\_\_\_\_

Date: \_\_\_\_\_

**For us to process your claims prescription (RX) receipts must contain:**

- Medication name
- Quantity Dispensed & Day Supply for medication(s)
- NDC (National Drug Code)
- Patient Name
- Pharmacy Name and Address
- Ordering physician's first and last name
- Cost of medication
- Date prescription was filled
- Prescription number
- Original prescription receipt (cash register receipts do not provide enough information)

**For us to process your claims, Medical, Dental, Vision receipts must contain:**

- Providers name, address, and tax identification number
- Diagnosis codes
- Procedure codes
- Date of service
- Itemized charges

**Contact the provider or pharmacy if you need additional information.**

**TAPE RECEIPT HERE**  
**In Date Order**

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**Nature of Illness or Injury**

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**Doctor's Name (if not on receipt)**

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**If Injury, Date Occured**

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**How, When, Where**

**TAPE RECEIPT HERE**  
**In Date Order**

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**Nature of Illness or Injury**

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**Doctor's Name (if not on receipt)**

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**If Injury, Date Occured**

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**How, When, Where**