



Thank you for choosing Regence for your health care coverage.

Please review the filing instructions located at the end of this form before you begin for helpful information regarding how to complete your claim so that it will process quickly and accurately.

Contact customer service using the toll-free number on your Regence Member Identification card if you have any questions, or communicate with the Live Help team on regence.com for on-line assistance. We are happy to serve you.

MEMBER INFORMATION				
Patient's Name (Last, First, M.I.)		Patient's Date of Birth (mm/dd/yyyy)		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"/> Dependent	
Policyholder's Address		City	State	ZIP Code
Patient's ID Number (3 letters followed by 9 numbers)		Group Name		Group Number
Does the patient have coverage from any other health plan including Medicare? <input type="checkbox"/> No. Please skip to Claim Details. <input type="checkbox"/> Yes. Please attach the Explanation of Benefits (EOB) statement from the primary plan with this claim, and complete the following information.				
Name of Other Health Plan		ID Number / Policy Number of Other Health Plan		Telephone Number of Other Health Plan

CLAIM DETAILS		
Name of Provider	Address where services were rendered	Date of Service (mm/dd/yyyy)
Diagnosis (describe illness and symptoms requiring treatment):		Total Charges
Briefly describe the service(s) you received:		
Have the charges been paid in full? <input type="checkbox"/> No. <input type="checkbox"/> Yes. Please attach proof of payment in full with your itemized bill.		
In what setting were these services performed? <input type="checkbox"/> Inpatient Hospital <input type="checkbox"/> Outpatient Hospital <input type="checkbox"/> Office/Clinic <input type="checkbox"/> Surgery Center <input type="checkbox"/> Skilled Nursing Facility <input type="checkbox"/> Home <input type="checkbox"/> Other _____		
If applicable, list the contact information of the physician that prescribed/ordered these services:		
Name	Address	Telephone Number

INTERNATIONAL SERVICES			
Is this claim for expenses incurred outside the U.S.A.? <input type="checkbox"/> No. Please skip to Accident / Injury. <input type="checkbox"/> Yes. Please supply an itemized bill and any available medical records when you submit the claim.			
Name of Provider	Country of Service	City of Service	Date of service (mm/dd/yyyy)
Diagnosis (describe illness and symptoms requiring treatment):		Total Charges	Currency Used
Briefly describe the service(s) you received:			

ACCIDENT / INJURY

Is this claim due to an accidental injury? <input type="checkbox"/> No. Please skip to Signature. <input type="checkbox"/> Yes. Please complete this section.	Date of accident (mm/dd/yyyy)	Where did the accident occur? <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> School <input type="checkbox"/> Auto <input type="checkbox"/> Other
How did the accident happen?		
Description of injury:		
Please Note: If there is another party that may be responsible to pay for these services, such as homeowner's or auto insurance, please finish submitting your claim then contact an agent in our Other Party Liability department at 877-633-7877 to assist you further.		

SIGNATURE

To be accepted, this form must be fully completed (as appropriate to the claim being submitted) signed, and have an itemized bill attached.		
Patient Signature (or legal guardian if patient cannot legally consent to services) ▶	Relationship to Patient <input type="checkbox"/> Self <input type="checkbox"/> Other	Date (mm/dd/yyyy)
Please Note: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.		

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.

▶ _____ Date _____
Signature (Subscriber or Patient)

Thank you for choosing Regence as your health plan administrator. We recommend that you make copies of everything that is submitted for your personal records.

Mail this claim to:
Regence BlueCross BlueShield of Utah
PO Box 30270
Salt Lake City, UT 84130-0270

INSTRUCTIONS FOR FILING A CLAIM

IMPORTANT:

- ◆ Use this form for all medical, pharmacy, dental, and vision services covered by Regence. If your policy utilizes a vendor for pharmacy, dental or vision services, contact the vendor for any necessary forms or instructions for filing your claim.
- ◆ If the services were rendered on a cruise ship or are related to a prescriptions purchase made outside of the United States, you may proceed using this form. All other service types rendered outside of the United States will need to be filed on the BlueCard Worldwide International Claim Form and submitted according to the instructions provided. Visit www.bluecardworldwide.com for additional information.
- ◆ You only need to fill out this form if your health care professional isn't filing the claim for you. Your health care professional can still file the claim for you if they are out-of-network with your policy; however, they are not required to do so.
- ◆ Payment is made directly to contracting health care professionals. We only send payment to you when the health care professional is out of network and there is evidence that you have paid in full for the services rendered.
- ◆ If services are a result of an accident or injury, complete the Accident/Injury section of the claim form. If there is another party that may be responsible to pay for these services, such as homeowner's or auto insurance, please contact an agent in our Other Party Liability department at 877-633-7877 to assist you further. You may still continue with your claim submission.
- ◆ If you have Medicare or other insurance coverage that is not already on file with Regence, or if it has changed or terminated, you will need to contact Regence to update your account to ensure your claim processes correctly and timely.

FILING RECOMMENDATIONS:

- ◆ Complete a separate claim form for each covered family member.
- ◆ Enclose itemized receipts and make copies for your records. It is helpful for receipts to include:
 - Patient's Name
 - Date of Service (mm/dd/yy)
 - Procedure Code(s)
 - Diagnosis Code(s) - ICD Format
 - Health care professional's Full Name, Credentials, Address, Phone Number and Tax ID Number and National Provider Identifier (NPI)
 - Total charge for each service rendered
- ◆ If the patient has Medicare or other health insurance coverage, and that other insurance coverage is primary and Regence is secondary, we need an Explanation of Benefits (EOB) for this service from the other insurance company when you send the completed form and itemized bill.