Blue Care Network of Michigan

A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

# Member Reimbursement Form

## Customer Service

1-800-662-6667
1-800-257-9980 (TTY users)
8 a.m. to 5:30 p.m. Monday through Friday

### HOW TO USE THIS FORM

Please use this form when you paid for medical services and are seeking reimbursement.

Use one form for each bill paid, and include receipts from medical providers along with a copy of your cancelled check (front and back) or credit card receipt. Send to:

Member Claim Inquiry – C225
Blue Care Network
P.O. Box 68767
Grand Rapids, MI 49516-8767

Please keep a copy of everything you send us.

### MEMBER INFORMATION

| | | | |
|---|---|---|---|
| Patient Name | | | Date of Birth |
| Subscriber Name | | Contract No. | |
| Address | City | State | Zip Code |
| Phone Day — Evening — | PCP who wrote referral | PCP Number (if known) | |

### PROVIDER / BILLING INFORMATION

| | | | |
|---|---|---|---|
| Provider Name | | Provider Name | |
| Address | | Address | |
| Phone | | Phone | |
| Services | | Services | |
| Date of Service | | Date of Service | |
| Total Charges | Total Paid | Total Charges | Total Paid |

*NOTE: If you are reporting more than two services, add a separate sheet for each item and supply the necessary documentation.*

### ADDITIONAL INFORMATION: Complete any information that applies.

| | | |
|---|---|---|
| 1. Was the service provided on an emergency basis? | ☐ Yes | ☐ No |
| 2. Was your BCN primary care physician notified? | ☐ Yes | ☐ No – Explain below |
| 3. Were you referred by your primary care physician? | ☐ Yes | ☐ No – Explain below |

If services were not performed by a BCN provider, please explain why.

Please explain the circumstances that led to your reimbursement request. (Attach additional sheets if necessary.)

### I CERTIFY THAT THE ABOVE STATEMENTS ARE CORRECT.

| | |
|---|---|
| Subscriber's Signature | Date |