Member Submitted Claim Form for Medical Services

ND

Note: Incomplete claim forms will be returned and will delay the processing of the claim.

Member Instructions

1. Complete section 1 and sign form
2. Ask your physician, healthcare provider or medical service supplier to complete section 2
3. If any other health insurance made payment on the claim, please include a copy of the Explanation of Benefits from that payer
4. Submit completed form (sections 1 and 2) along with any receipts, itemized statements and proof of payment by:
   - Fax: (701) 282-1888
   - Mail: BCBSND
Attn: Medical Claims Department
4510 13th Ave S
Fargo, ND 58121
5. Retain copies of all documents for your records

Physician/Provider/Supplier Instructions

1. Complete section 2 and sign form
2. Return completed form to:
   - Patient
   - Blue Cross Blue Shield of North Dakota (BCBSND) by:
     - Fax: (701) 282-1888
     - Mail: BCBSND
Attn: Medical Claims Department
4510 13th Ave S
Fargo, ND 58121

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Section 1 – Patient Information

Patient's Name

Address

City | State | Zip

Phone Number	Date of Birth (*MM/DD/YYYY*)
Gender ☐ Male ☐ Female	Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other

PICA

Insured Information

Insured's Name

Insured's ID Number	Phone Number

Address

City | State | Zip

Patient's or Authorized Person's Signature

I authorize the release of any medical or other information necessary to process this claim.

Signature	Date (*MM/DD/YYYY*)

Section 2 – Physician or Supplier Information

Date of Accident (*MM/DD/YYYY*)	Referring Physician NPI

For Local Use Only

Diagnosis Code(s)

____________ ____________ ____________ ____________

____________ ____________ ____________ ____________

____________ ____________ ____________ ____________

4510 13th Avenue South, Fargo, North Dakota 58121

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Section 2 – Physician or Supplier Information

Date(s) of Service		Place of Service	Procedure, Services or Supplies (Explain Unusual Circumstances)		Description of Services	Diagnosis Pointer	Charges	Days or Units	Rendering Provider ID #
From (MM/DD/YYYY)	To (MM/DD/YYYY)		CPT/HCPCS	Modifier					

Federal Tax ID Number ☐ SSN ☐ EIN	Patient's Account Number	Total Charge

Service Facility Location Information

Facility NPI

Billing Provider Information

Phone Number	Billing NPI

Signature of Physician or Supplier Including Degrees or Credentials

Signature	Date (*MM/DD/YYYY*)

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