Member Submitted Claim Form for Medical Services Instructions

When to use this form

Use this form if you received services from a non-participating provider. Please submit a separate form for each billing provider.

If your provider is in-network, you do not need to submit this form. Your in-network provider will submit a claim on your behalf. Instead, use the Find a Doctor tool to verify if your provider is non-participating before proceeding.

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

Information you will need

Details from your provider

Beyond the provider's name and address, there are specific details needed that may appear on your bill or statement. If not, contact the provider before completing this form and request the following:

- **Date of service** – The date you received the medical service.
- **Place of service** – All allowed services have been provided with checkboxes on the form aligned to https://www.cms.gov/medicare/coding-billing/place-of-service-codes/code-sets.
- **National Provider Identifier (NPI)** – A unique identification number given to your provider. This can be found on your bill or by asking your provider directly.
- **Diagnosis code** – A number used by your provider to explain the reason for your visit. If you don't have the diagnosis code, you will need to provide the reason for the visit, including diagnosis, condition or symptoms.
- **CPT/HCPCS (procedure/service codes) with any modifiers** – Unique code used to describe the medical services received. If you don't have the CPT/HCPCS, provide the description or service performed.
- **Amount charged** – Amount charged is the total amount on the statement prior to any discounts applied.
- **Amount paid** – Amount paid by you to your provider for the service. This will allow us to reimburse you accordingly.

Proof of service and payment

You will be required to show proof of service and payment including any discounts received by uploading one of the following:

- Itemized statement from the provider showing any discounts provided and that the bill has been paid in full
- Receipt of payment

Member Instructions

1. Complete each section and sign form
2. If any other health insurance made payment on the claim, please include a copy of the Explanation of Benefits from that payer
3. Submit completed form 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
4. Retain copies of all documents for your records

Member Submitted Claim Form for Medical Services

Patient Information

☐ Myself ☐ Spouse ☐ Dependent Age 11 or Younger ☐ Dependent Age 12 or Older ☐ Other

Patient Information

Patient First Name	MI	Patient Last Name
Patient Gender ☐ Male ☐ Female		Patient Date of Birth
Phone Number		Member ID Number
Address Line 1		
Address Line 2		
City	State	ZIP Code

Submitter Information

Submitter First Name	Submitter Last Name
Patient's Relationship to Submitter ☐ Spouse ☐ Dependent	Phone Number
Address Line 1	
Address Line 2	
City	State	ZIP Code

Billing Provider Information

Provider Name		
Provider Address Line 1		
Provider Address Line 2		
Provider City	Provider State	Provider ZIP Code

Physician or Supplier Information

Service 1

Beginning Date of Service*	Ending Date of Service*

Place of Service*

- ☐ Office (11)
- ☐ Telehealth Provided in Patient's Office (02) -Modifier 95
- ☐ Homeless Shelter (04)
- ☐ Home (12)
- ☐ Independent Laboratory (81)
- ☐ Durable Medical Equipment (DME) (12)
- ☐ Outpatient Facility (22)
- ☐ Other (99)

Billing Provider NPI*	Referring Provider NPI	Rendering Provider
1. Do you have a Diagnosis Code?* ☐ Yes ☐ No	Diagnosis Code	Diagnosis Pointer

Reason for Visit or Purchase?* (If no to 1)

2. Do you have a CPT/HCPCS Code?*
☐ Yes ☐ No

CPT/HCPCS Code* (If yes to 2)	Modifier (If yes to 2)

Describe the Service you Received* (If no to 2)

3. Did your Service Exceed More than 1 Day?* ☐ Yes ☐ No	How Many Days?* (If no to 3)
4. Did your Service Exceed More than 1 Unit?* ☐ Yes ☐ No	How Many Units?* (If no to 4)
Amount Charged*	Amount Paid*

Physician or Supplier Information

Service 2

Beginning Date of Service*	Ending Date of Service*

Place of Service*

- ☐ Office (11)
- ☐ Telehealth Provided in Patient's Office (02) -Modifier 95
- ☐ Homeless Shelter (04)
- ☐ Home (12)
- ☐ Independent Laboratory (81)
- ☐ Durable Medical Equipment (DME) (12)
- ☐ Outpatient Facility (22)
- ☐ Other (99)

Billing Provider NPI*	Referring Provider NPI	Rendering Provider
1. Do you have a Diagnosis Code?* ☐ Yes ☐ No	Diagnosis Code	Diagnosis Pointer

Physician or Supplier Information

Service 2

Reason for Visit or Purchase?* (If no to 1)

2. Do you have a CPT/HCPCS Code?*

☐ Yes ☐ No

CPT/HCPCS Code* (If yes to 2)	Modifier (If yes to 2)

Describe the Service you Received* (If no to 2)

3. Did your Service Exceed More than 1 Day?* ☐ Yes ☐ No	How Many Days?* (If no to 3)
4. Did your Service Exceed More than 1 Unit?* ☐ Yes ☐ No	How Many Units?* (If no to 4)
Amount Charged*	Amount Paid*

Physician or Supplier Information

Service 3

Beginning Date of Service*	Ending Date of Service*

Place of Service*

☐ Office (11) ☐ Telehealth Provided in Patient's Office (02) -Modifier 95

☐ Homeless Shelter (04) ☐ Home (12)

☐ Independent Laboratory (81) ☐ Durable Medical Equipment (DME) (12)

☐ Outpatient Facility (22) ☐ Other (99)

Billing Provider NPI*	Referring Provider NPI	Rendering Provider
1. Do you have a Diagnosis Code?* ☐ Yes ☐ No	Diagnosis Code	Diagnosis Pointer

Reason for Visit or Purchase?* (If no to 1)

2. Do you have a CPT/HCPCS Code?*

☐ Yes ☐ No

CPT/HCPCS Code* (If yes to 2)	Modifier (If yes to 2)

Describe the Service you Received* (If no to 2)

3. Did your Service Exceed More than 1 Day?* ☐ Yes ☐ No	How Many Days?* (If no to 3)

Physician or Supplier Information	
Service 3	
4. Did your Service Exceed More than 1 Unit?* ☐ Yes ☐ No	How Many Units?* (If no to 4)
Amount Charged*	Amount Paid*

Physician or Supplier Information		
Service 4		
Beginning Date of Service*	Ending Date of Service*	
Place of Service* ☐ Office (11) ☐ Telehealth Provided in Patient's Office (02) -Modifier 95 ☐ Homeless Shelter (04) ☐ Home (12) ☐ Independent Laboratory (81) ☐ Durable Medical Equipment (DME) (12) ☐ Outpatient Facility (22) ☐ Other (99)		
Billing Provider NPI*	Referring Provider NPI	Rendering Provider
1. Do you have a Diagnosis Code?* ☐ Yes ☐ No	Diagnosis Code	Diagnosis Pointer
Reason for Visit or Purchase?* (If no to 1)		
2. Do you have a CPT/HCPCS Code?* ☐ Yes ☐ No		
CPT/HCPCS Code* (If yes to 2)	Modifier (If yes to 2)	
Describe the Service you Received* (If no to 2)		
3. Did your Service Exceed More than 1 Day?* ☐ Yes ☐ No	How Many Days?* (If no to 3)	
4. Did your Service Exceed More than 1 Unit?* ☐ Yes ☐ No	How Many Units?* (If no to 4)	
Amount Charged*	Amount Paid*	

Physician or Supplier Information

Service 5

Beginning Date of Service*	Ending Date of Service*

Place of Service*

☐ Office (11)
☐ Telehealth Provided in Patient's Office (02) -Modifier 95
☐ Homeless Shelter (04)
☐ Home (12)
☐ Independent Laboratory (81)
☐ Durable Medical Equipment (DME) (12)
☐ Outpatient Facility (22)
☐ Other (99)

Billing Provider NPI*	Referring Provider NPI	Rendering Provider
1. Do you have a Diagnosis Code?* ☐ Yes ☐ No	Diagnosis Code	Diagnosis Pointer

Reason for Visit or Purchase?* (If no to 1)

2. Do you have a CPT/HCPCS Code?* ☐ Yes ☐ No

CPT/HCPCS Code* (If yes to 2)	Modifier (If yes to 2)

Describe the Service you Received* (If no to 2)

3. Did your Service Exceed More than 1 Day?* ☐ Yes ☐ No	How Many Days?* (If no to 3)
4. Did your Service Exceed More than 1 Unit?* ☐ Yes ☐ No	How Many Units?* (If no to 4)
Amount Charged*	Amount Paid*

Physician or Supplier Information

Service 6

Beginning Date of Service*	Ending Date of Service*

Place of Service*

☐ Office (11)
☐ Telehealth Provided in Patient's Office (02) -Modifier 95
☐ Homeless Shelter (04)
☐ Home (12)
☐ Independent Laboratory (81)
☐ Durable Medical Equipment (DME) (12)
☐ Outpatient Facility (22)
☐ Other (99)

Billing Provider NPI*	Referring Provider NPI	Rendering Provider
1. Do you have a Diagnosis Code?* ☐ Yes ☐ No	Diagnosis Code	Diagnosis Pointer

Physician or Supplier Information

Service 6

Reason for Visit or Purchase?* (If no to 1)

2. Do you have a CPT/HCPCS Code?*

☐ Yes ☐ No

CPT/HCPCS Code* (If yes to 2)	Modifier (If yes to 2)

Describe the Service you Received* (If no to 2)

3. Did your Service Exceed More than 1 Day?* ☐ Yes ☐ No	How Many Days?* (If no to 3)
4. Did your Service Exceed More than 1 Unit?* ☐ Yes ☐ No	How Many Units?* (If no to 4)
Amount Charged*	Amount Paid*

Physician or Supplier Information

Service 7

Beginning Date of Service*	Ending Date of Service*

Place of Service*

☐ Office (11)
☐ Telehealth Provided in Patient's Office (02) -Modifier 95
☐ Homeless Shelter (04)
☐ Home (12)
☐ Independent Laboratory (81)
☐ Durable Medical Equipment (DME) (12)
☐ Outpatient Facility (22)
☐ Other (99)

Billing Provider NPI*	Referring Provider NPI	Rendering Provider
1. Do you have a Diagnosis Code?* ☐ Yes ☐ No	Diagnosis Code	Diagnosis Pointer

Reason for Visit or Purchase?* (If no to 1)

2. Do you have a CPT/HCPCS Code?*

☐ Yes ☐ No

CPT/HCPCS Code* (If yes to 2)	Modifier (If yes to 2)

Describe the Service you Received* (If no to 2)

3. Did your Service Exceed More than 1 Day?* ☐ Yes ☐ No	How Many Days?* (If no to 3)

Physician or Supplier Information	
Service 7	
4. Did your Service Exceed More than 1 Unit?* ☐ Yes ☐ No	How Many Units?* (If no to 4)
Amount Charged*	Amount Paid*

Physician or Supplier Information		
Service 8		
Beginning Date of Service*		Ending Date of Service*
Place of Service* ☐ Office (11) ☐ Telehealth Provided in Patient's Office (02) -Modifier 95 ☐ Homeless Shelter (04) ☐ Home (12) ☐ Independent Laboratory (81) ☐ Durable Medical Equipment (DME) (12) ☐ Outpatient Facility (22) ☐ Other (99)		
Billing Provider NPI*	Referring Provider NPI	Rendering Provider
1. Do you have a Diagnosis Code?* ☐ Yes ☐ No	Diagnosis Code	Diagnosis Pointer
Reason for Visit or Purchase?* (If no to 1)		
2. Do you have a CPT/HCPCS Code?* ☐ Yes ☐ No		
CPT/HCPCS Code* (If yes to 2)		Modifier (If yes to 2)
Describe the Service you Received* (If no to 2)		
3. Did your Service Exceed More than 1 Day?* ☐ Yes ☐ No		How Many Days?* (If no to 3)
4. Did your Service Exceed More than 1 Unit?* ☐ Yes ☐ No		How Many Units?* (If no to 4)
Amount Charged*		Amount Paid*

Signature	
Submitter First Name	Submitter Last Name
Signature	

Blue Cross Blue Shield of North Dakota
4510 13th Avenue South • Fargo, ND 58121

Blue Cross Blue Shield of North Dakota (BCBSND) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, gender identity, sexual orientation or sex. BCBSND does not exclude people or treat them differently because of race, color, national origin, age, disability, gender identity, sexual orientation or sex. BCBSND:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as: written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provides free language services to people whose primary language is not English, such as: qualified interpreters and information written in other languages.

If you need these services, please call Member Services at 1-844-363-8457 (toll-free) or through the North Dakota Relay at 1-800-366-6888 or 711. If you believe BCBSND has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, gender identity, sexual orientation or sex, you can file a grievance with: Civil Rights Coordinator, 4510 13th Ave. S. Fargo, ND 58121, 701-297-1638 or North Dakota Relay at 800-366-6888 or 711, 701-282-1804 (fax), CivilRightsCoordinator@bcbsnd.com (email) (unencrypted emails present a risk.)

You can file a grievance in person or by mail, fax, or email within 180 days of the date of the alleged discrimination. Grievance forms are available at http://www.bcbsnd.com/report or by calling 1-844-363-8457. If you need help filing a grievance, the Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Ave. S.W. Room 509F, HHH Building, Washington, DC 20201, 800-368-1019 or 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Español (Spanish) – ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia con el idioma. También hay disponibles ayudas y servicios auxiliares adecuados para proporcionar información en formatos accesibles sin cargo. Llame al 1-844-363-8457 (TTY: 1-800-366-6888 o 711) o hable con su proveedor.

Deutsch (German) – ACHTUNG: Wenn Sie Deutsch sprechen, steht Ihnen kostenfreie fremdsprachliche Unterstützung zur Verfügung. Außerdem sind kostenlos entsprechende Hilfsmittel und Dienstleistungen zur Bereitstellung von Informationen in barrierefreien Formaten erhältlich. Rufen Sie 1-844-363-8457 (TTY: 1-800-366-6888 oder 711) an oder sprechen Sie mit Ihrem Anbieter.

中文 (Chinese) – 注意：如果您說中文，我們可以為您提供免費的語言協助服務。亦免費提供適當的輔助工具和服務，以無障礙格式提供資訊。請撥打 1-844-363-8457（聽障服務專線TTY：1-800-366-6888 或 711）或與您的醫療服務提供者討論。

Oromoo (Oromo) – XIYYEEFFANNOO: Afaan Oromoo dubbattu yoo ta'e, tajaajilli gargaarsa afaan hiikuu kaffaltii malee ni argama. Gargaarsi dabalataa gargaaraadhaaf tajaajilli sirrii ta'ee fi odeeffannoo bifa dhaqqabamaa ta'een kennuunis bilisaan ni argama. Bilbili 1-844-363-8457 (TTY: 1-800-366-6888 or 711) ykn dhiyeessaa kee waliin haasa'i.

Tiếng Việt (Vietnamese) – CHÚ Ý: Nếu quý vị nói Tiếng Việt, có sẵn các dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Chúng tôi cũng cung cấp miễn phí các dịch vụ và hỗ trợ bổ sung thích hợp để cung cấp thông tin ở các định dạng dễ tiếp cận. Xin gọi 1-844-363-8457 (TTY: 1-800-366-6888 hoặc 711) hoặc nói chuyện với nhà cung cấp của quý vị.

Ikirundi (Bantu – Kirundi) – Wiyubare: Nimba uvuga Ikirundi, wemerewe ubufasha bwo kuronka ururimi ku buntu. Wemerewe kandi ubufasha bukwiye bw'inyongera na serivisi vyo gutanga amakuru mu buryo bworoshe ku buntu. Hamagara kuri 1-844-363-8457 (TTY: 1-800-366-6888 canke 711) canke uvugane n'ujejwe kugufasha.

العربية (Arabic) – تنبيه: إذا كنت تتحدث العربية، فتتوفر لك خدمات المساعدة اللغوية المجانية. تتوفر أيضًا وسائل وخدمات إضافية مناسبة لتقديم المعلومات بتنسيقات سهلة الاستخدام من دون أي تكلفة. اتصل على الرقم: 1-844-363-8457 (الهاتف النصي: 1-800-366-6888 أو 711) أو تحدث إلى مقدم الرعاية المتابع لك.

Kiswahili (Swahili) – ZINGATIA: Ikiwa unazungumza Kiswahili, huduma za msaada wa lugha bila malipo zinapatikana kwa ajili yako. Vifaa na huduma saidizi zinazofaa ili kutoa taarifa katika miundo inayoweza kufikiwa pia hupatikana bila malipo. Piga simu 1-844-363-8457 (TTY: 1-800-366-6888 au 711) au zungumza na mtoa huduma wako.

Русский (Russian) – ВНИМАНИЕ! Если Вы говорите по-русски, Вы можете воспользоваться бесплатными услугами переводчика. Также предоставляется дополнительная бесплатная помощь и услуги отображения информации в доступных форматах. Позвоните по телефону 1-844-363-8457 (TTY: 1-800-366-6888 или 711) или обратитесь к своему поставщику услуг.

日本語 (Japanese) – お知らせ：日本語をお話しになる方は無料の言語アシスタンスサービスをご利用いただけます。情報を利用可能な形式で提供するための適切な補助具やサービスも無料でご利用いただけます。1-844-363-8457（TTY：1-800-366-6888 または 711）にお電話いただくか、医療提供者にご相談ください。

नेपाली (Nepali) – ध्यान दिनुहोस्: तपाईं नेपाली भाषा बोल्नुहुन्छ भने तपाईंका लागि निःशुल्क भाषा सहायता सेवाहरू उपलब्ध छन्। पहुँचयोग्य ढाँचाहरूमा जानकारी प्रदान गर्न उपयुक्त सहायक प्रविधि र सेवाहरू पनि निःशुल्क उपलब्ध छन्। 1-844-363-8457 (TTY: 1-800-366-6888 वा 711) मा कल गर्नुहोस् वा आफ्नो प्रदायकसँग कुरा गर्नुहोस्।

Français (French) – ATTENTION : Si vous parlez français, des services d'assistance linguistique sont disponibles gratuitement. Vous pouvez aussi bénéficier gratuitement de l'accès à des outils et services auxiliaires appropriés dans des formats accessibles. Appelez le 1-844-363-8457 (ATS : 1-800-366-6888 ou 711) ou adressez-vous à votre fournisseur.

한국어 (Korean) – 주의: 한국어를 사용하시는 경우, 무료 언어 지원 서비스가 제공됩니다. 접근 가능한 형식으로 정보를 제공하는 적절한 보조 수단 및 서비스도 무료로 이용하실 수 있습니다. 1-844-363-8457(TTY: 1-800-366-6888 또는 711)번으로 전화하거나 담당 의료 서비스 제공자와 상의하십시오.

Tagalog (Tagalog) – PAUNAWA: Kung nagsasalita kayo ng Tagalog, mayroong kayong magagamit na libreng tulong na mga serbisyo sa wika. Mayroon ding mga angkop na auxiliary na tulong at serbisyo para magbigay ng impormasyon sa mga naa-access na format na makukuha ng walang singil. Tumawag sa 1-844-363-8457 (TTY: 1-800-366-6888 o 711) o makipag-usap sa iyong provider.

Norsk (Norwegian) – OBS: Hvis du snakker norsk, er gratis språkhjelp tilgjengelig for deg. Passende ytterligere hjelpemidler og tjenester for å oppgi informasjon i tilgjengelige formater er også tilgjengelig kostnadsfritt. Ring 1-844-363-8457 (TTY: 1-800-366-6888 eller 711) eller snakk med leverandøren din.

Diné (Navajo) – YÁ'ÁT'ÉÉH NITSÁHÁKEES: Díí Diné bizaad bee yáníłti'go, t'áá íiyisí t'áá bee yáhoot'éél dóó baa áháyá' át'é. T'áá jíík'ehígíí bee na'ách'ąą' holne' dóó t'áá shikaadéé' danilį́į́'ígíí t'áá jíík'ehgo bee hóló, dóó t'áá íiyisí doo béésh bee hadooleeł da. 1-844-363-8457 bee hojiij' (TTY: 1-800-366-6888 dóó 711), dóó naaltsoos nínízingo bee iiná bee nił hane'ígíí nihił ch'á hodool'į'.