

Mail to :
 Blue Benefit Administrators of Massachusetts
 P.O. Box 55917
 Boston, MA 02205-5917
 Fax to: (877) 596.2583



Medical Claim Form

Please note: Each claim must be accompanied by an itemized bill from the facility or provider showing both procedure and diagnosis codes.

Employee Information		
1. Last Name:	2. First Name:	3. Mid:
4. Street Address:	4a. Apt./Unit #	
5. Birth Date:	6. Marital Status:	
7. City:	8. State:	9. Zip:
10. Home Phone:	11. Alternate Phone:	
12. Email Address:		
13. Employer Name:		
14. Group Number (from your ID Card):		
15. Member Identification Number (from your ID Card):		
Patient Information		
16. Last Name:	17. First Name:	18. Mid:
19. Street Address:	19a. Apt./Unit #	
20. City:	21. State:	22. Zip:
23. Birth Date:	24. Patient's Sex: Male Female	
25. Relationship to Participant: Self Spouse Child Other		
26. Home Phone:	27. Alternate Phone:	
28. In addition to coverage under this program, is the patient covered under any other insurance providing health care benefits or services?		
No Yes If "Yes", please complete below:		
c. Name of Insurer		
d. Policy or Certificate Number	e. Effective Date of Coverage:	
Claim Information		
29. Is this claim the result of an accidental injury? No Yes If "Yes", please complete below:		
29a. Injury Date:	29b. Where accident occurred and details:	
30. Was the injury in any way work related? No Yes		
31. Date of Service(s):		
32. Provider(s) of Service:		
33. Reimbursement should be provided to: Member Provider of Service		

I certify that the above is complete and correct and that I am claiming benefits only for charges incurred by the patient above. Authorization is hereby given to any hospital, physician, or other provider which participated in any way in my care and treatment to release to BBA any medical information which they in their judgment deem necessary to the adjudication of this claim.

Participant Signature

Date