Mail to :
Blue Benefit Administrators of Massachusetts
P.O. Box 55917
Boston, M**A** 022**0**5-**5917**
Fax to: (8**77**) **5962583**

BLUE Benefit ADMINISTRATORS OF MASSACHUSETTS
An independent licensee of the Blue Cross and Blue Shield Association.

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:
month day year
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: 0 Male 0 Female
month day year
25. Relationship to Participant: 0 Self 0 Spouse 0 Child 0 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?

0 No 0 Yes If "Yes", please complete below:

c. Name of Insurer

d. Policy or Certificate Number e. Effective Date of Coverage: / /
month day year

Claim Information

29. Is this claim the result of an accidental injury? 0 No 0 Yes If "Yes", please complete below:
29a. Injury Date: / / 29b. Where accident occurred and details:
month day year
30. Was the injury in any way work related? 0 No 0 Yes
31. Date of Service(s):
32. Provider(s) of Service:
33. Reimbursement should be provided to: 0 Member 0 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** _____