PBC_blk_no_bleeds

**Microsoft Weight Management Program**

**Final Billing Claim Form**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Section 1: Must be completed by patient/member** | | | | | | | |
| Premera Blue Cross Identification Number (found on your Premera Blue Cross ID card): | | | | Email address: | | | |
| Patient/Member name (PRINT): Last | | | First | | | | M.I. |
| Patient/Member address (Street/P.O. Box): | | City: | | | State: | ZIP: | |
| Patient/Member is (check one):  Employee  Spouse/Domestic Partner | Patient/Member birth date (m/d/yyyy): | | | |  | | |
| Name of referring physician: | | | | | | | |
| PLEASE NOTE: In submitting this form to Premera Blue Cross or having it submitted for you, you authorize the service provider named in the attached bills to release medical and other information to Premera Blue Cross as needed to verify Plan coverage. | | | | | | | |
| PATIENT SIGNATURE: | | | | | DATE (m/d/yyyy): | | |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Section 2: Must be completed by approved Weight Management Program** | | | | | | | | |
| Monitoring physician: | | | Provider type (IM, GP, Nutritionist): | | | | | |
| Primary diagnosis:  Congestive Heart Failure  Coronary Heart Disease  Diabetes  Hyperlipidemia  Hypertension  Depression | | | | | | | | |
| Facility name: | | | Tax ID: | | | | | |
| Facility address (Street/P.O. Box): | | City: | | | State: | ZIP: | | Telephone number: |
| Total amount billed: $ | | | Billing period: | | | | | |
| Amount paid by member: $ | | | Date started: | | | | | |
| Length of program in which member has enrolled: | | | Total cost of program: $ | | | | | |
| Cost of services incurred to date: $ | | |  | | | | | |
|  | | |  | | | | | |
| **Program specifics** | | | | | | | | |
| **Biometric Measures** | **At start of program** | | | **At completion of  maintenance program** | | | | |
|  |  | | | **3 months** | | | | **Final** |
| Body Mass Index (BMI) |  | | |  | | | |  |
| Weight |  | | |  | | | |  |
| % Body Fat |  | | |  | | | |  |
| Lean Body Mass |  | | |  | | | |  |
| Blood Pressure |  | | |  | | | |  |
| HDL |  | | |  | | | |  |
| LDL |  | | |  | | | |  |
| Triglycerides |  | | |  | | | |  |
| Total Cholesterol |  | | |  | | | |  |
| HDL/LDL Ratio |  | | |  | | | |  |
| Fasting Glucose |  | | |  | | | |  |
|  |  | | |  | | | |  |
| **Confirmation of Completion** | ***Patient Start Date***  ***(m/d/yyyy)*** | | | ***Maintenance Program  Completion Date (m/d/yyyy)*** | | | | |
| PROVIDER SIGNATURE: | | | | | | | DATE (m/d/yyyy): | |

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**Procedures for Filing a Claim**

Warning: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

California Residents: For your protection, California law requires notice of the following: Any person who knowingly and with intent to defraud or deceive any insurance company files a statement of claim containing any materially false, incomplete or misleading information is guilty of a crime and may be subject to fines, confinement in a state prison and substantial civil penalties.

For submission of a claim:

1. All items must be completed.
2. This form is not valid unless signed by the physician and covered member (when applicable).
3. Send the completed claim form and bills to:

**(Members and providers)**

**Premera Blue Cross**  
Attn: Weight Management Claims   
PO Box 91059, MS 181   
Seattle, WA 98111-9159

**Fax:** 800-676-1477

**(Providers only)**  
**Secure email:** Visit [**https://securemail.premera.com/login**](https://securemail.premera.com/login)

and enter an active email address. When prompted send the   
secure email to MicrosoftWMP@premera.com.

1. If you have questions call Premera Customer Service at 800-676-1411.

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