Complete and fax to: 800-843-1114



BLUE CROSS

requesting application of in-network benefits for their services.

MEMBER/PATIENT:	Date of birth:			
	Suffix: Group #:			
REQUESTING PROVIDER:		SERVICING PR		
Address:		Address:		
City: <u>State:</u>	ZIP:	City:	State:	ZIP:
Phone: Ex	tension:	Phone:		Extension:
Fax:		Fax:		
Contact person:				
Tax ID (required):		Tax ID (required):		
NPI # (if available):	NPI # (if available):			
REQUIRED: Complete all fields that apply for	place of service. To e	nable Site Of Serv	ice boxes download	form before completing
FACILITY:		Outpatient h		
Address:		Inpatient hospital		
City: <u>State: ZIP:</u>		 Office Ambulatory surgical center 		
Tax ID (required):				
NPI # (if available):		Home		
Phone: Fax:			g Infusion Center	
		U Other		
Date scheduled: Existing re		ference #: Expiration date:		
	Existing refer	ence #:	Ex	piration date:
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Note: Unless specifically requested elsewhere in this document, do not send a DNA or other genetic sample, or the results of any genetic typing, test, or analysis, including DNA.

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