PREMERA | BLUE CROSS
An Independent Licensee of the Blue Cross Blue Shield Association

PO Box 91059
Seattle, WA 98111

Instructions for requesting reimbursement

Use the Claim Reimbursement Request form when you have expenses from a provider who does not bill Premera directly. If you'd like to request reimbursement for your prescriptions, use the Prescription Drug Reimbursement form instead.

This form can be used for requesting reimbursement on the following types of claims:

- Vision hardware (glasses, contacts)
- Medical care (including eye exams)
- Dental care
- Durable medical equipment (DME) (such as breast pumps, crutches, wheelchairs)
- International services received outside of the United States

Checklist of required documents

If you're requesting reimbursement for vision hardware (glasses, contacts), please include:

☐ A copy of the receipt from your provider

If you're requesting reimbursement for medical care (including eye exams) dental care, or durable medical equipment, please include:

- Proof of payment (if applicable)
- An itemized bill, including:
    - Name of the patient
    - Diagnosis code (ICD-10). You can get this from your provider
    - Date(s) of service
    - Procedure code (CPT-4, HCPCS, ADA, or UB-04). You can get this from your provider
    - Name, address, and IRS tax ID of the provider
    - Itemized charge for each service received

Notes: Any highlights or modifications to your bill may cause a delay in processing your claim. One member per claim form. If same provider, you can use one claim form to submit for multiple dates of service.

Next steps

To help process your claim, the form must be fully completed, signed, and returned with all required documents. Send your documents one of two ways:

Email through your Secure Inbox:

Simply sign in to your account at premera.com/wy and select Secure Inbox. Scan and send this completed form and any required documents back to us as a secure email attachment.

Mail to:

Premera Blue Cross
PO Box 91059
Seattle, WA 98111-9159

Questions?

Call: 800-995-2420 (TTY: 711), Monday through Friday, 5 a.m. to 8 p.m. Pacific Time

Email: Sign in to your account at premera.com/wy and select Secure Inbox

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Claim Reimbursement Request

General Information (See your Premera member ID card)

Patient's name (first, MI, last) ______________________

Subscriber name (Who the insurance is listed under) ______________________

Prefix ________ ID number ______________ Group number ______________ Relationship to patient ______________

Patient's phone number ______________________

I consent to receive voicemails at this number from Premera containing my personal health information related to this claim.

Patient's birthday (mm/dd/yyyy)______________________

Is this claim the result of an accident or injury? This will help determine if any other parties, such as workers' compensation, can help pay for your care. ☐ **Yes** ☐ **No**

Section A — Other Health Plan Information

Does the patient have any other health insurance coverage? ☐ **Yes*** ☐ **No** (skip to section B)

*If the patient's other insurance pays for care first, you must submit the claim to them before we can process your request.

Name of other health plan ______________ Phone number ______________ ID number ______________

Please attach the explanation of benefits (EOB) from the other health plan.

Section B — Claim Details

This claim is for:

☐ **Vision hardware** (glasses, contacts) (attach your itemized bill and skip to section D)

☐ **Medical care** (including eye exams)

☐ **Dental care**

☐ **Durable medical equipment (DME)**

Has the patient paid the total amount due for this claim? ☐ **Yes** ☐ **No**

Additional required information:

Provider name ______________

Provider address/city/state/ZIP code ______________

Procedure code(s) ______________

Provider phone number ______________

Date(s) of service (month/day/year) ______________

Diagnosis code(s) ______________

Continued on back

Section C — International Claims (includes cruise ships)

☐ **Yes**
Then, attach an itemized bill, any available medical records, and complete this section

☐ **No**
Then, skip to section D

Type of visit (check all that apply):

☐ Lab ☐ Office visit ☐ Urgent care

City of service ____________________

Country of service ____________________

Describe illness or injury

____

____

Total amount charged ____________________

Currency used to pay for care ____________________

Section D — Signature

Print this form and sign below

Printed name (first, MI, last)

____

Patient signature (or legal guardian) ____________________

Date (mm/dd/yyyy) ____________________

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Please note: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

PREMERA | BLUE CROSS

Discrimination is Against the Law

Premera Blue Cross (Premera) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Premera does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, gender identity, or sexual orientation. Premera provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats). Premera 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, contact the Civil Rights Coordinator. If you believe that Premera has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Civil Rights Coordinator ─ Complaints and Appeals, PO Box 91102, Seattle, WA 98111, Toll free: 855-332-4535, Fax: 425-918-5592, TTY: 711, Email AppealsDepartmentInquiries@Premera.com. You can file a grievance in person or by mail, fax, or email. 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 SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Language Assistance

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 800-722-1471 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 800-722-1471（TTY：711）。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 800-722-1471 (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 800-722-1471 (TTY: 711) 번으로 전화해 주십시오.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 800-722-1471 (телетайп: 711).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 800-722-1471 (TTY: 711).

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 800-722-1471 (телетайп: 711).

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 800-722-1471 (TTY: 711)។

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。800-722-1471（TTY:711）まで、お電話にてご連絡ください。

ማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 800-722-1471 (መስማት ለተሳናቸው: 711).

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 800-722-1471 (TTY: 711).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 800-722-1471 (رقم هاتف الصم والبكم: 711).

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 800-722-1471 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 800-722-1471 (TTY: 711).

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 800-722-1471 (TTY: 711).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 800-722-1471 (TTY: 711).

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 800-722-1471 (ATS : 711).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 800-722-1471 (TTY: 711).

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 800-722-1471 (TTY: 711).

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 800-722-1471 (TTY: 711).

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با (TTY: 711) 800-722-1471 تماس بگیرید.

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