

Direct Member Reimbursement Form

Thank you for being a Blue Cross® Blue Shield® of Arizona (BCBSAZ) member. Please use this form to request reimbursement for covered medical care and supplies that were paid out-of-pocket. To receive timely reimbursement, please be sure you and your Primary Care Provider (PCP) or other health care professionals fill out this form completely.

- Type or print requested information.
- Ask your provider(s) to help you complete all the information requested in Step 2.
- Attach itemized receipts or claim forms for each service. (Do not staple items.)
- A separate reimbursement request form should be completed for each member and provider.
- Please keep a copy of each itemized bill or receipt for your records.
- Do not submit a form if your physician or other health care professional is also filing a claim to BCBSAZ for the same service.

STEP 1 – Member information

Last name First name Middle initial

Member ID number _____ Date of birth _____

Street address City State Zip

() _____

Phone number

If you are completing this form for the member, please provide your name, address, and phone number.

Last name First name Middle Initial

Street address City State Zip

() _____

Phone number

Include paperwork showing you have the legal right to act for the member (such as a valid Power of Attorney or Medicare's Appointment of Representative Form). You can find the Appointment of Representative Form on our website (www.azbluemedicare.com) or you can call Member Services and ask them to send you the form.

Information about the medical care and supplies you paid for is required. You may find this information on your doctor's bill or you can call your doctor's office and ask them for the information. Send us *copies* of your bills, receipts, or statements. Use the chart on the next page to tell us what you paid for. Please send us proof of payment, including the date you paid and how you paid (check, credit card, etc.).

STEP 2 – Service information

Date of Service (mm/dd/yy)	Place of Service or Item	Codes for Procedures, Services, or Supplies	Diagnosis Code or Illness	Amount You Paid	How you Paid (Cash, Check, Credit Card, etc.)	Number of Visits or Units

Provider Name Provider Tax ID number

Street address City State Zip

If you have questions or need assistance about the reimbursement process, we are happy to help. Please call Member Services at 480-937-0409 (in Arizona) or toll-free at 1-800-446-8331 (TTY users should call 711). We are here from 8:00 a.m. to 8:00 p.m., Monday through Friday from April 1 to September 30; and seven days a week from October 1 to March 31.

If all information has been correctly submitted, you can expect your claim to be processed within 60 business days of receipt by BCBSAZ. THIS IS NOT A GUARANTEE OF PAYMENT. Actual payment for covered services will be paid at the appropriate level according to your plan benefit.

Before you submit your claim:

1. Be sure all fields are completed.
2. Make photocopies of all receipts and completed forms. Receipts will not be returned.
3. Write your BCBSAZ member ID number on all paperwork you submit.
4. Fill out a separate claim form for each member.

Mail to:
 Blue Cross Blue Shield of Arizona
 PO Box 29234
 Phoenix, AZ 85038-9234

Need large print or another format?

Please contact our Member Services number at 480-937-0409 (in Arizona) or toll-free at 1-800-446-8331 for additional information. (TTY users should call 711). We are here from 8:00 a.m. to 8:00 p.m., Monday through Friday from April 1 to September 30; and seven days a week from October 1 to March 31.

Blue Cross Blue Shield of Arizona (BCBSAZ) offers BluePathway HMO and BlueJourney PPO Medicare Advantage plans. Blue Cross Blue Shield of Arizona Advantage, a separate but wholly owned subsidiary of BCBSAZ, offers Blue Medicare Advantage Standard, Classic and Plus HMO plans.