

Blue Care Network

Blue Care Network of Michigan is a nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

25925 Telegraph Rd.
P.O. Box 5043
Southfield, MI 48086-5043
(800) 662-6667
Member Inquiry Line
8:00 a.m. - 5:00 p.m.
Monday - Friday

(Please check one.)

MEMBER CLAIM FORM

Applies to bills sent to you in error. Please attach copies of any bills.

MEMBER REIMBURSEMENT FORM

Applies to services for which you have paid and are requesting reimbursement. Please attach any receipts from providers, pharmacy (including medication dispensed), etc., and copies of cancelled check(s), both front & back sides.

MEMBER INFORMATION

PATIENT NAME ▶		BIRTHDATE	
SUBSCRIBER NAME ▶		BCN CONTRACT NO.	
ADDRESS		CITY	STATE ZIP CODE
PHONE ▶ HOME - BUS. -	NAME OF PCP WHO WROTE REFERRAL		PCP NUMBER (IF KNOWN)

PROVIDER / BILLING INFORMATION

PROVIDER NAME	PROVIDER NAME
ADDRESS	ADDRESS
PHONE	PHONE
SERVICES	SERVICES
DATE OF SERVICE ▶	DATE OF SERVICE ▶
TOTAL CHARGES ▶ \$	IF REQUESTING REIMBURSEMENT, TOTAL PAID ▶ \$
TOTAL CHARGES ▶ \$	IF REQUESTING REIMBURSEMENT, TOTAL PAID ▶ \$

ADDITIONAL INFORMATION: Complete any information that applies.

1. Was the above service rendered on an emergency basis? Yes No
2. Was your Blue Care Network Primary Care Physician notified? Yes No - If No, explain below.
3. Were you referred to the attending provider by your Primary Care Physician? Yes No - If No, explain below.

If applicable, please explain why services were not performed by a BCN participating provider. ▶

Please explain the circumstances regarding your Claim / Reimbursement request. (Attach additional sheets if necessary.) ▶

I CERTIFY THAT THE ABOVE STATEMENTS ARE CORRECT.

SUBSCRIBER'S SIGNATURE ▶

DATE