

NOTE: A separate claim form must be completed for each patient and each provider. Please check with your provider of care to determine if charges have already been filed.

SUBSCRIBER INFORMATION:

1. BCBSNE ID NUMBER: Enter the identification number and any alpha prefix as shown on your Blue Cross and Blue Shield ID Card. (If you are age 65 or older, this number may not be the same as your Medicare number).
2. SUBSCRIBER'S DAYTIME PHONE NUMBER: The area code and phone number of the subscriber. This can be a landline or cell number.
3. SUBSCRIBER'S NAME: Enter the subscriber's name as shown on subscriber's ID card.
4. SUBSCRIBER'S ADDRESS: Enter the home address of the subscriber.
5. SUBSCRIBER'S DATE OF BIRTH: Enter the date of birth of the subscriber providing the month as two digits (MM), day as two digits (DD) and year as four digits (YYYY).
6. SUBSCRIBER'S SEX: Check the appropriate box for the sex of the subscriber.

PATIENT INFORMATION

7. PATIENT'S NAME: Enter the patient's FULL LEGAL NAME (not a nickname); please include "Sr." or "Jr." if applicable.
8. PATIENT'S ADDRESS: Enter the home address of the patient.
9. PATIENT'S DATE OF BIRTH: Enter the date of birth of the patient providing the month as two digits (MM), day as two digits (DD) and year as four digits (YYYY).
10. PATIENT'S SEX: Check the appropriate box for the sex of the patient.
11. PATIENT'S RELATIONSHIP TO SUBSCRIBER: Check the appropriate box to indicate the relationship of the patient to the subscriber.

SERVICE INFORMATION

12. WAS THE SERVICE RELATED TO EMPLOYMENT? Check the appropriate box to indicate if the service was due to an accident or illness related to employment.
13. WAS THE SERVICE RELATED TO AN AUTO ACCIDENT? Check the appropriate box to indicate if the service was the result of an auto accident.
14. OTHER TYPE OF ACCIDENT? Check the appropriate box to indicate if the service was related to another type of accident other than auto; if YES, please explain.
15. WAS THE SERVICE PROVIDED IN NEBRASKA? Check the appropriate box to indicate if services were provided in Nebraska.
16. Please attach the following information which will allow the claim(s) to be reviewed without delay. With the claim form submit an itemized statement from your provider that includes the provider's complete address, dates of service, charges, procedures and diagnosis codes, Tax ID Number and NPI Number.

MAIL THE REQUIRED INFORMATION TO:

Blue Cross Blue Shield of Nebraska
P.O. Box 3248
Omaha, NE 68180-0001