

Subscriber's claim form | BlueCard Program

This form should only be used when filing claims to another Blue Cross and Blue Shield Plan.

A separate claim form must be completed for each patient and each provider (prescription drugs from multiple providers can be on the same claim for the same patient). All information sections must be completed. Please check with your provider of care to see if he or she has already filed any of these charges for you.

Subscriber information

Blue Cross and Blue Shield ID number		Subscriber's phone		
Subscriber's first name	Middle initial	Last name		
Subscriber's address	City	State	ZIP	
Subscriber's employer				

Patient information

Patient's first name		Middle initial	Last name		
Patient's relationship to insured Self Spouse Child Other		Gender Male Female		Date of birth (mm/dd/yyyy)	
Complete for dependent child over age 19					
Is patient a full time student? Yes No		If yes, what school?			
Number of credit hours taken at time of care?		Undergraduate Yes No		Graduate Yes No	

Service information

Service related to employment? Yes No	Auto accident? Yes No	If Yes, date of accident (mm/dd/yyyy)	Other accident type? Yes No
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Diagnosis or description of illness or injury requiring treatment

Date illness began (mm/dd/yyyy)	Total of charges submitted
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Name and address of the attending practitioner

I certify the above is complete and correct and that I am claiming benefits for charges incurred by the above named patient.

Subscriber's signature

Date of signature (mm/dd/yyyy)

Please return this signed form to:

Arkansas Blue Cross Blue Shield
P.O. Box 2181
Little Rock, AR 72203