Blue Cross Blue Shield of Michigan

MEMBER APPLICATION FOR PAYMENT CONSIDERATION Dental

Fill out online, print, sign and mail with original receipts to:

BLUE CROSS BLUE SHIELD OF MICHIGAN
P.O. BOX 49
DETROIT, MI 48231-0049

THIS INFORMATION CAN BE TAKEN FROM YOUR BCBSM I.D. CARD

SUBSCRIBER'S ALPHA/NUMERIC CONTRACT NUMBER	
Alpha	Numeric

MEMBER INFORMATION

SUBSCRIBER'S LAST NAME	SUBSCRIBER'S FIRST NAME	BCBSM GROUP NUMBER

SUBSCRIBER'S STREET ADDRESS

CITY	STATE	ZIP CODE

PATIENT INFORMATION

PATIENT'S FIRST NAME	SEX	MEDICARE HIB NUMBER
	☐ M ☐ F	

DATE OF INJ/ILL/LMP	ADMISSION DATE	DISCHARGE DATE

WAS THIS RELATED TO AN AUTO ACCIDENT?	WAS THIS WORK RELATED ?	OTHER HEALTH INSURANCE?
☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO

NAME OF OTHER INSURANCE	POLICY NUMBER

I certify that the above information is true and the enclosed material is correct and unaltered and the expenses were incurred by the patient. I understand all material submitted becomes the property of Blue Cross Blue Shield of Michigan and will not be returned. I realize false receipt or fraudulent alterations of these materials will result in civil or criminal prosecution. I authorize the release of any information necessary to process or review this claim.

DATE	PHONE	Sign after printing	SUBSCRIBER'S SIGNATURE

To speed up our processing remember to:

- Separate claim forms are necessary for different patients. You will also need and use another claim form for each of the different programs (medical, dental, vision, hearing).
- Mail only original receipts including all pertinent information on provider's letterhead. Without this information your claim will be returned to you. Cash register receipts, cancelled checks, money orders, and personal itemizations cannot be used in benefit payment consideration.
- If the patient has Medicare coverage, fill in the Medicare number including alpha characters. Be sure you include the Medicare Summary Notice that was sent explaining the charges paid or not paid by Medicare. This is not required for dental, vision or hearing services.
- If the patient has other health insurance that has processed the service, be sure you include the Explanation of Benefit statement that was sent explaining the charges paid or not paid.
- Make copies of the original receipts for your files before submitting the original. All materials submitted will be retained for our files and cannot be returned to you.

YOUR RIGHT TO CONFIDENTIALITY: We will not release any information about you except: (1) When you ask us to in writing or (2) When release (to another insurance company for example) is necessary to process or review a claim. We will tell you which information we release to whom, if you request it.

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