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
Diagnosis or description of illness or injury requiring treatment			
Date illness began (mm/dd/yyyy)	**Total of charges submitted**		
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