



# SUBSCRIBER APPLICATION FOR PAYMENT

DIRECT TO BLUE CROSS BLUE SHIELD OF MICHIGAN FOR PAYMENT. IF YOUR SERVICES WERE RENDERED BY A MICHIGAN PROVIDER, HE/SHE MAY BILL THESE CLAIM BENEFITS.

1. SUBSCRIBER'S LAST NAME										2. SUBSCRIBER'S FIRST NAME																			
3. SUBSCRIBER'S STREET ADDRESS																				4. GROUP NUMBER									
3 8 0 9 LAKE EASTBROOK BLVD																													
5. CITY					6. STATE					7. ZIP CODE					8. CONTRACT NUMBER														
GRAND RAPIDS					MI					4 9 5 4 6																			
9. PATIENT'S FIRST NAME					10. SEX					11. DATE OF BIRTH					12. RELATIONSHIP CODE					13. OTHER INSURANCE					14. WORKMAN'S COMP.				
					<input type="checkbox"/> M <input type="checkbox"/> F					MO. DAY YR.					<input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> DEPENDENT					<input type="checkbox"/> YES <input type="checkbox"/> NO					<input type="checkbox"/> YES <input type="checkbox"/> NO				
15. MEDICARE HIB NUMBER										16. DATE OF INJ/ILL/LMP					17. AUTO ACCIDENT					18. ADMISSION DATE					19. DISCHARGE DATE				
										MO DAY YR					<input type="checkbox"/> YES <input type="checkbox"/> NO					MO DAY YR					MO DAY YR				

I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND THE ATTACHED MATERIAL IS CORRECT AND UNALTERED AND THAT THE EXPENSES WERE INCURRED BY THE ABOVE NAMED PATIENT. I UNDERSTAND THAT ALL MATERIAL SUBMITTED BECOMES THE PROPERTY BLUE CROSS AND BLUE SHIELD OF MICHIGAN AND MAY NOT BE RETURNED. I REALIZE FALSE RECEIPTS 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.

SIGNATURE										DATE					AREA CODE					TELEPHONE NUMBER				
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PROVIDER INFORMATION																								
PROVIDER NAME										PROVIDER ADDRESS LINE 1														
PROVIDER ADDRESS LINE 2																								
CITY										STATE					ZIP CODE					PROVIDER TAX I.D.				

### FOR BLUE CROSS AND BLUE SHIELD USE ONLY. DO NOT WRITE IN SPACES BELOW

CLAIMS RECEIPT DATE	PROVIDER CODE	ATTACH COUNT	PREPARED BY	PRIOR AUTHORIZATION NUMBER	PROGRAM					
					<input type="checkbox"/> O/S <input type="checkbox"/> FOR <input type="checkbox"/> COMP					
1	DATE OF SERVICE	DATE OF SV (TO)	LOC	TYPE	SERIAL	CP	APPROVED AMOUNT	AMOUNT CHARGED	DX CODE	QUANTITY
	D OF N	MISC. DATE	M-1	M-2	M-3	WHY	PROVIDER CODE	MEDICARE REASONABLE	MEDICARE DEDUCTIBLE	
2	DATE OF SERVICE	DATE OF SV (TO)	LOC	TYPE	SERIAL	CP	APPROVED AMOUNT	AMOUNT CHARGED	DX CODE	QUANTITY
	D OF N	MISC. DATE	M-1	M-2	M-3	WHY	PROVIDER CODE	MEDICARE REASONABLE	MEDICARE DEDUCTIBLE	
3	DATE OF SERVICE	DATE OF SV (TO)	LOC	TYPE	SERIAL	CP	APPROVED AMOUNT	AMOUNT CHARGED	DX CODE	QUANTITY
	D OF N	MISC. DATE	M-1	M-2	M-3	WHY	PROVIDER CODE	MEDICARE REASONABLE	MEDICARE DEDUCTIBLE	
4	DATE OF SERVICE	DATE OF SV (TO)	LOC	TYPE	SERIAL	CP	APPROVED AMOUNT	AMOUNT CHARGED	DX CODE	QUANTITY
	D OF N	MISC. DATE	M-1	M-2	M-3	WHY	PROVIDER CODE	MEDICARE REASONABLE	MEDICARE DEDUCTIBLE	
5	DATE OF SERVICE	DATE OF SV (TO)	LOC	TYPE	SERIAL	CP	APPROVED AMOUNT	AMOUNT CHARGED	DX CODE	QUANTITY
	D OF N	MISC. DATE	M-1	M-2	M-3	WHY	PROVIDER CODE	MEDICARE REASONABLE	MEDICARE DEDUCTIBLE	
6	DATE OF SERVICE	DATE OF SV (TO)	LOC	TYPE	SERIAL	CP	APPROVED AMOUNT	AMOUNT CHARGED	DX CODE	QUANTITY
	D OF N	MISC. DATE	M-1	M-2	M-3	WHY	PROVIDER CODE	MEDICARE REASONABLE	MEDICARE DEDUCTIBLE	

DOCUMENT NUMBER - DO NOT WRITE IN THIS AREA

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 RELEASED TO WHOM, IF YOU REQUEST IT.