PREMERA | BLUE CROSS
An Independent Licensee of the Blue Cross Blue Shield Association

P.O. Box 91059
Seattle, WA 98111

Instructions for requesting reimbursement

Use the Claim Reimbursement Form when you have expenses from a provider who does not bill Premera directly. If you'd like to request reimbursement for your prescriptions, use the Prescription Drug Reimbursement form instead.

This form can be used for requesting reimbursement on the following types of claims:

- Vision hardware (glasses, contacts)
- Medical (includes eye exams)
- Dental

Checklist of required documents

If you're requesting reimbursement for vision hardware (glasses, contacts), please include:

- ☐ Copy of the receipt from your provider

If you're requesting reimbursement for medical (includes eye exams) or dental care, please include:

- ☐ Proof of payment (if applicable)
- ☐ An itemized bill, including:
  - ☐ Name of the patient
  - ☐ Date of service
  - ☐ Name, address, and IRS tax ID of the provider
  - ☐ Diagnosis code (ICD-10)
    You can get this from your provider
  - ☐ Procedure code (CPT-4, HCPCS, ADA, or UB-04)
    You can get this from your provider
  - ☐ Itemized charge for each service received

Note: Any highlights or modifications to your bill may cause a delay in processing your claim.

Next steps

To help process your claim, the form must be fully completed, signed, and returned with all required documents. Send your documents one of two ways:

Email through your Secure Inbox:
Simply sign into your account at premera.com and select **Secure Inbox**.

Scan and send this completed form and any required documents back to us as a secure email attachment.

Mail to:
Premera Blue Cross
PO Box 91059
Seattle, WA 98111-9159

Questions?

Call:
800-722-1471 (TTY: 711)
Monday through Friday

5 a.m. to 8 p.m. Pacific Time

Email:
Sign into your account at premera.com and select Secure Inbox

Notice of availability and nondiscrimination **800-722-1471 | TTY: 711**

Call for free language assistance services and appropriate auxiliary aids and services.
Llame para obtener servicios gratuitos de asistencia lingüística, y ayudas y servicios auxiliares apropiados.
呼吁提供免费的语言援助服务和适当的辅助设备及服务。
呼籲提供免費的語言援助服務和適當的輔助設備及服務。
Gọi cho các dịch vụ hỗ trợ ngôn ngữ miễn phí và các hỗ trợ và dịch vụ phụ trợ thích hợp.
무료 언어 지원 서비스와 적절한 보조 도구 및 서비스를 신청하십시오.
Звоните для получения бесплатных услуг по переводу и других вспомогательных средств и услуг.
Tumawag para sa mga libreng serbisyo ng tulong sa wika at angkop na mga karagdagang tulong at serbisyo.
Зверніться за безкоштовною мовною підтримкою та відповідними додатковими послугами.
សូមហៅទូរសព្ទទៅសេវាជំនួយភាសាដោយឥតគិតថ្លៃ ព្រមទាំងសេវាកម្ម និងជំនួយចាំបាច់ដែលសមរម្យផ្សេងៗ។
無料言語支援サービスと適切な補助器具及びサービスをお求めください。
ለነፃ የቋንቋ እርዳታ አገልግሎቶች እና ተገቢ ድጋፍ ሰጪ አጋዥ መሳሪያዎችን እና አገልግሎቶችን ለማግኘት በስልክ ቁጥር
Tajaajiloota deeggarsa afaan bilisaa fi gargaarsaa fi tajaajiloota barbaachisaa ta'an argachuuf bilbilaa.
મુફત ભાષા સહાયતા સેવાઓ અને ઉચિત સહાયક ચીજો અને સેવાઓ વાપરવા કોલ કરો।
Fordern Sie kostenlose Sprachunterstützungsdienste und geeignete Hilfsmittel und Dienstleistungen an.
ໂທເພື່ອຮັບການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ ແລະ ການບໍລິການ ແລະ ການຊ່ວຍເຫຼືອພິເສດທີ່ເໝາະສົມແບບບໍ່ເສຍຄ່າ.
Rele pou w jwenn sèvis asistans lengwistik gratis ak èd epi sèvis oksilyè ki apwopriye.
Appelez pour obtenir des services gratuits d'assistance linguistique et des aides et services auxiliaires appropriés.
Zadzwoń, aby uzyskać bezpłatną pomoc językową oraz odpowiednie wsparcie i usługi pomocnicze.
Ligue para serviços gratuitos de assistência linguística e auxiliares e serviços auxiliares adequados.
Chiama per i servizi di assistenza linguistica gratuiti e per gli ausili e i servizi ausiliari appropriati.
اتصل للحصول على خدمات المساعدة اللغوية المجانية والمساعدات والخدمات المناسبة.
برای خدمات کمک زبانی رایگان و کمک‌ها و خدمات امدادی مقتضی، تماس بگیرید.

Discrimination is against the law. Premera Blue Cross (Premera) complies with applicable Federal and Washington state civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex, including sex characteristics, intersex traits, pregnancy or related conditions, sexual orientation, gender identity, and sex stereotypes. Premera does not exclude people or treat them less favorably because of race, color, national origin, age, disability, sex, sexual orientation, or gender identity. Premera provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats). Premera provides free language assistance services to people whose primary language is not English, which may include qualified interpreters and information written in other languages. If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact our Civil Rights Coordinator. If you believe that Premera has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity, you can file a grievance with: Civil Rights Coordinator — Complaints and Appeals, PO Box 91102, Seattle, WA 98111, Toll free: 855-332-4535, TTY: 711, Fax: 425-918-5592, Email AppealsDepartmentInquiries@Premera.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Ave SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html. You can also file a civil rights complaint with the Washington State Office of the Insurance Commissioner, electronically through the Office of the Insurance Commissioner Complaint Portal available at https://www.insurance.wa.gov/file-complaint-or-check-your-complaint-status, or by phone at 800-562-6900, 360-586-0241 (TDD). Complaint forms are available at https://fortress.wa.gov/oic/onlineservices/cc/pub/complaintinformation.aspx.

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Seattle, WA 98111-9159

Claim Reimbursement Request

General Information (See ID card)

Patient's name (first, MI, last)

Subscriber name (Who the insurance is listed under)

Prefix ID number Group number

Relationship to patient

Patient's phone number Patient's birthday (mm/dd/yyyy)

Is this claim the result of an accident or injury?
This will help determine if any other parties, such as workers' compensation, can help pay for your care.

☐ Yes ☐ No

☐ I consent to receive voicemails at this number from Premera containing my personal health information related to this claim.

Section A — Other Health Plan Information

Does the patient have any other health insurance coverage?

☐ Yes* ☐ No
Then, skip to section B

*If the patient's other insurance pays for care first, you must submit the claim to them before we can process your request.

Name of other health plan Phone number

ID number

Please attach the Explanation of Benefits (EOB) from the other health plan.

Section B — Claim Details

This claim is for:

☐ **Vision hardware** (glasses, contacts)
Then, attach your itemized bill and skip to section D

☐ **A medical visit** (includes eye exams)

☐ **A dental visit**

Has the patient paid the total amount due for this claim?

☐ Yes
Then, attach proof of payment

☐ No

Additional required information:

Provider name

Provider address/City/State/Zip Code

Procedure code(s)

Provider phone number

Date of service (month/day/year)

Diagnosis code(s)

Continued on back

Section C — International Claims (includes cruise ships)

Did you receive care outside of the U.S.?

☐ Yes
Then, attach an itemized bill, any available medical records, and complete this section

☐ No
Then, skip to section D

Type of Visit (check all that apply)

☐ Hospital ☐ Office
☐ Lab ☐ Urgent Care

City of service

Country of service

Describe illness or injury

Total amount charged

Currency used to pay for care

Section D — Signature

To help process your claim, this form must be fully completed, signed and returned. Please refer to the checklist on the instructions page to ensure you've included all required documents.

Patient signature (or legal guardian)

x

Printed name (first, MI, last)

Date (mm/dd/yyyy)

Next Steps

Send completed forms and documents one of two ways:

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We also welcome your feedback at premeralistens.com.

Email:
Sign in to your account at premera.com and select Secure Inbox

Please note: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.