Blue Cross Blue Shield of Michigan

MEMBER APPLICATION FOR PAYMENT CONSIDERATION Accidental Dental

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

Blue Cross Blue Shield of Michigan
Member Reimbursement Mail Code: 0010
600 E. Lafayette Blvd.
Detroit, MI 48226
Fax to : 1-844-318-5146

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	BIRTH DATE

CITY	STATE	ZIP CODE

PATIENT INFORMATION

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

DATE OF INJ/ILL/LMP	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

SUBSCRIBER NAME	SUBSCRIBER BIRTH DATE

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 expedite processing remember to:

- Use a separate Member Application for Payment Consideration for each patient. If the patient has Medicare coverage, be sure to include the Medicare number including alpha characters.
- Gather all materials necessary to complete your reimbursement:
  - Ask your dentist for a statement of treatment completed including CDT codes, impacted teeth numbers, all fees charged, and what you paid. This is considered your receipt and will help expedite your reimbursement.
  - If the patient has other health insurance that has processed the service, be sure to include the Explanation of Benefits statement that was sent explaining the charges paid or not paid.
- Make copies of all your original documents including this completed form. All original documents submitted will be retained for our files and cannot be returned to you.
- Mail or fax all original documents to the contact information listed at the top of this form.

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.