# Member Billing Form

Blue Care Network of Michigan

Confidence comes with every card.

## Customer Service

**1-800-662-6667**
**711** (TTY users)

8 a.m. to 5:30 p.m. Monday through Friday

## HOW TO USE THIS FORM

This form is for bills you receive from providers who don't participate with us. Use it to send us a bill that you haven't paid. Use one form for each bill you receive. Send to:

Member Claim Inquiry – C225
Blue Care Network
P.O. Box 68767
Grand Rapids, MI 49516-8767

If you paid the bill, call Customer Service, and ask for our Member Reimbursement form. You can also get a form online at **bcbsm.com/billform**.

Keep a copy of everything you send us.

## MEMBER INFORMATION

| | | | | |
|---|---|---|---|---|
| Patient name | | | Date of birth | |
| Subscriber name | | Contract no. | | |
| Address | | City | State | ZIP Code |
| Phone | Day —<br>Evening — | PCP who wrote referral | PCP number (if known) | |

## SERVICE INFORMATION

| | | |
|---|---|---|
| 1. Was the service rendered on an emergency basis? | ☐ Yes | ☐ No |
| 2. Was your BCN primary care physician notified? | ☐ Yes | ☐ No – Explain below |
| 3. Were you referred to the attending provider by your primary care physician? | ☐ Yes | ☐ No – Explain below |

Explain why services were not performed by a BCN participating provider.

Explain the circumstances regarding this service. (Attach additional sheets if necessary.)

## I CERTIFY THAT THE ABOVE STATEMENTS ARE CORRECT.

| Subscriber's Signature | Date |
|---|---|
| | |