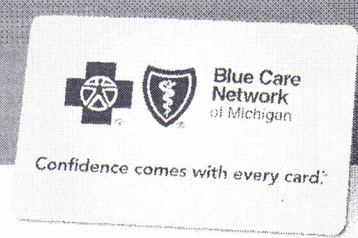


# Member Billing Form



## 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](http://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 — Evening —	PCP who wrote referral	PCP number (if known)

### SERVICE INFORMATION

- |  |                              |   |
|--|------------------------------|---|
| 1. Was the service rendered on an emergency basis?                             | <input type="checkbox"/> Yes | <input type="checkbox"/> No                 |
| 2. Was your BCN primary care physician notified?                               | <input type="checkbox"/> Yes | <input type="checkbox"/> No – Explain below |
| 3. Were you referred to the attending provider by your primary care physician? | <input type="checkbox"/> Yes | <input type="checkbox"/> 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
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