PREMERA | BLUE CROSS BLUE SHIELD OF ALASKA
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
Blue Shield of Alaska
PO Box 91059
Seattle, WA 98111-9159

Questions?

Call:
800-508-4722 (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

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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 ☐ No
Then, attach proof of payment

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)

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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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Questions?

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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.