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

P.O. Box 21762
Eagan, MN 55121

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 in to your account at premera.com and select **Contact Us > Send Email**.

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 21762
Eagan, MN 55121

Questions?

Call:
800-809-9361 (TTY: 711)
Monday through Friday

8 a.m. to 6 p.m. Pacific Time

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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
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

Describe illness or injury

Country of service

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) | Printed name (first, MI, last) | Date (mm/dd/yyyy)

X

Next Steps

Send completed forms and documents one of two ways:

Email through your Secure Inbox:
Simply sign in to your account at premera.com and select **Contact Us > Send Email**.

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 21762
Eagan, MN 55121

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We welcome your feedback at premeralistens.com.

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.

PREMERA | BLUE CROSS BLUE SHIELD OF ALASKA

Discrimination is Against the Law

Premera Blue Cross Blue Shield of Alaska (Premera) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, gender identity, or sexual orientation. Premera does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, gender identity, or sexual orientation. Premera provides free aids and services to people with disabilities 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 services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, contact the 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, gender identity, or sexual orientation, you can file a grievance with: Civil Rights Coordinator ─ Complaints and Appeals, PO Box 91102, Seattle, WA 98111, Toll free: 855-332-4535, Fax: 425-918-5592, TTY: 711, Email AppealsDepartmentInquiries@Premera.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the 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.

Language Assistance

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 800-809-9361 (TTY: 711).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 800-809-9361 (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 800-809-9361 (TTY: 711) 번으로 전화해 주십시오.

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 800-809-9361 (TTY: 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 800-809-9361 (телетайп: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 800-809-9361 (TTY：711）。

MO LOU SILAFIA: Afai e te tautala Gagana fa'a Sāmoa, o loo iai auaunaga fesoasoan, e fai fua e leai se totogi, mo oe, Telefoni mai: 800-809-9361 (TTY: 711).

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 800-809-9361 (TTY: 711).

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。800-809-9361（TTY:711）まで、お電話にてご連絡ください。

PAKDAAR: Nu saritaem ti Ilocano, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Awagan ti 800-809-9361 (TTY: 711).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 800-809-9361 (TTY: 711).

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки.
Телефонуйте за номером 800-809-9361 (телетайп: 711).

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 800-809-9361 (TTY: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 800-809-9361 (TTY: 711).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 800-809-9361 (TTY: 711).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 800-809-9361 (رقم هاتف الصم والبكم: 711).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 800-809-9361 (TTY: 711).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 800-809-9361 (ATS : 711).

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 800-809-9361 (TTY: 711).

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 800-809-9361 (TTY: 711).

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 800-809-9361 (TTY: 711) تماس بگیرید.