



1800 Ninth Avenue  
PO Box 91015  
Seattle, WA 98111-9115



Regence BlueShield serves select counties in the state of Washington and is an Independent Licensee of the Blue Cross and Blue Shield Association

### MEDICAL CLAIM FORM

Use this form to submit reimbursement requests for services received from a non-network provider. Please complete a separate form for each family member. The time limit for filing claims is one year from the date of service/purchase. **Note:** This form may be used for claims for PEBB and SEBB Uniform Medical Plans. Network providers will submit claims to Regence directly.

1. Complete the information below and on the back of this form.
2. Attach itemized bills, including patient's name, date of service, diagnosis, procedures and charges.
3. Retain copies for your records. Receipts will not be returned.
4. Sign the completed form where indicated at the bottom of this page and submit the completed claim form to:

Regence BlueShield  
Attn: UMP Claims  
PO Box 1106  
Lewiston, ID 83501-1106  
or by fax to: 1 (877) 357-3418

Payments will be mailed to the address on file for the subscriber. You can verify your address by calling PEBB Customer Service at 1 (888) 849-3681 or SEBB Customer Service at 1 (800) 628-3481.

UMP Identification Number (include alpha characters)				
Patient's Last Name		Patient's First Name		MI
Patient's Date of Birth	Patient's Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Patient's Relationship to Subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse OR certified domestic partner (DP) <input type="checkbox"/> Dependent		Daytime Phone Number
Subscriber's Last Name		Subscriber's First Name		MI
Group Name <b>Uniform Medical Plan</b>		Group Number		

#### OTHER INSURANCE INFORMATION

Are you or any family members on UMP covered by another plan? If so, please respond to the following:

Medical coverage?  Yes  No      Vision coverage?  Yes  No  
Dental coverage?  Yes  No      Prescription coverage?  Yes  No  
With Orthodontia?  Yes  No

If YES to any of the above, is this coverage:  Group  Individual

Are you or any family members covered by Medicare?  Yes  No (If YES, please specify:  Part A  Part B  Part C

IF THE ANSWER TO ANY OF THE ABOVE QUESTIONS IS "YES," please complete the section(s) below. If you have more than one additional policy, attach information on a separate sheet of paper.

Name of Other Group Insurance Plan	Subscriber's Name	ID Number	Relationship to Subscriber	Date of Birth
Address for Submitting Claims		City	State	ZIP Code
This Coverage is For: <input type="checkbox"/> Subscriber <input type="checkbox"/> Spouse/DP <input type="checkbox"/> Child(ren) <input type="checkbox"/> Family	If children of divorced parents are covered by more than one plan, please indicate name of the person with legal custody.		Numbers that identify you to other group (ID numbers, etc.)	
Subscriber's Employer (if applicable)		<input type="checkbox"/> Active <input type="checkbox"/> Retiree	Effective Date of this Plan	

If the patient paid for services in cash, please indicate type of service received. \_\_\_\_\_

To the extent my request for reimbursement relates to an over the counter (OTC) COVID-19 test, I certify that any OTC COVID-19 test was purchased by the participant, beneficiary, or enrollee at a licensed and established retailer for personal use, the test is not for surveillance, travel, employment or non-diagnostic purposes, the test is not for resale, and has not been or will not be reimbursed by another source.

I hereby certify that all information given is correct and receipts are attached. I further certify that all services rendered or items purchased were for the family member named. I understand that it is a crime to knowingly provide false or misleading information and that doing so may result in civic or criminal prosecution.

\_\_\_\_\_  
Signature (Subscribe or Patient)

\_\_\_\_\_  
Date

UMP ID Number \_\_\_\_\_

**Receipts must contain:**

- Provider's name and address
- Provider's tax ID number (TIN)
- Provider's national provider identifier (NPI) number
- Diagnosis and procedure codes
- Itemized charges
- Date(s) of service

For each date of service please complete the following:

- Name of illness and injury
- Provider's name (if not on receipt)
- If injury, date occurred
- If injury, how, when, where

\_\_\_\_\_  
Name of illness and injury

\_\_\_\_\_  
Provider's name (if not on receipt)

\_\_\_\_\_  
If injury, date occurred

\_\_\_\_\_  
If injury, how, when, where

\_\_\_\_\_  
Name of illness and injury

\_\_\_\_\_  
Provider's name (if not on receipt)

\_\_\_\_\_  
If injury, date occurred

\_\_\_\_\_  
If injury, how, when, where

\_\_\_\_\_  
Name of illness and injury

\_\_\_\_\_  
Provider's name (if not on receipt)

\_\_\_\_\_  
If injury, date occurred

\_\_\_\_\_  
If injury, how, when, where