Excellus

A nonprofit independent licensee of the BlueCross BlueShield Association

BlueHealthy Dollars
Reimbursement Form

Mail completed form and all required information to :

Excellus BlueCross BlueShield
P.O. Box 21146
Eagan, MN 55121-0146

PLEASE REVIEW AND LEGIBLY COMPLETE ALL SECTIONS (1-4) OF THIS FORM

Please Note-*If you do not have all of the required information please contact the provider of service for assistance prior to submitting your claim. Failure to supply all of the required information may result in delayed processing and/or subsequent return or denial of your claim submission.*

If your address has changed or is incorrect, please call our Customer Service Department at the telephone numbers listed on your identification card.

SECTION 1
INFORMATION REQUIRED FOR REIMBURSEMENT

COPIES OF ALL BILLS/RECEIPTS FOR QUALIFIED EXPENSES **MUST BE SUBMITTED** WITH THIS FORM IN ORDER FOR REIMBURSEMENT TO BE CONSIDERED. BALANCE BILL, CANCELLED CHECKS ETC. ARE **NOT** ACCEPTABLE. BILLS MUST ***CLEARLY*** INDICATE **ALL OF THE FOLLOWING**:

1-FULL NAME AND DATE OF BIRTH OF MEMBER RECEIVING SERVICES

2-NAME AND ADDRESS OF THE INDIVIDUAL OR BUSINESS/ORGANIZATION PROVIDING THE SERVICE(S)

3-DATE FOR **EACH** SERVICE RENDERED

4-CHARGE FOR **EACH** SERVICE RENDERED

5-ALL CLAIMS FOR REIMBURSEMENT MUST BE SUBMITTED WITHIN 12 MONTHS FROM THE DATE SERVICES WERE RENDERED IN ORDER TO BE CONSIDERED FOR PAYMENT.

SECTION 2
SUBSCRIBER INFORMATION *Please enter all information exactly as shown on your ID card*

SUBSCRIBER'S LAST NAME	SUBSCRIBER'S FIRST NAME	INITIAL	SUBSCRIBER IDENTIFICATION NUMBER

ADDRESS-NUMBER AND STREET	CITY	STATE	ZIP CODE

SECTION 3
SERVICE INFORMATION *Please complete all sections below for each individual service rendered*

MEMBER'S FULL NAME	MEMBER'S DATE OF BIRTH	RELATIONSHIP TO SUBSCRIBER	DATE(S) OF SERVICE	SERVICE INFORMATION	AMOUNT
LAST NAME: ☐ FIRST NAME: ☐	____/____/________ *mm dd yyyy*	☐ SELF ☐ SPOUSE ☐ CHILD	FROM: ___/___/___	☐ HEALTH RELATED CLASSES FOR ADULTS *S9451/Dx. Z7189* ☐ WEIGHT MANAGEMENT PROGRAMS *S9449/Dx. Z7189* ☐ HEALTH CLUB/GYM MEMBERSHIP *S9446/Dx. Z7189* ☐ CHILDREN'S FITNESS ACTIVITIES *S9451/Dx. Z7189* PROVIDED BY: ____________	$ ________
LAST NAME: ☐ FIRST NAME: ☐	____/____/________ *mm dd yyyy*	☐ SELF ☐ SPOUSE ☐ CHILD	FROM: ___/___/___	☐ HEALTH RELATED CLASSES FOR ADULTS *S9451/Dx. Z7189* ☐ WEIGHT MANAGEMENT PROGRAMS *S9449/Dx. Z7189* ☐ HEALTH CLUB/GYM MEMBERSHIP *S9446/Dx. Z7189* ☐ CHILDREN'S FITNESS ACTIVITIES *S9451/Dx. Z7189* PROVIDED BY: ____________	$ ________
LAST NAME: ☐ FIRST NAME: ☐	____/____/________ *mm dd yyyy*	☐ SELF ☐ SPOUSE ☐ CHILD	FROM:___/___/___	☐ HEALTH RELATED CLASSES FOR ADULTS *S9451/Dx. Z7189* ☐ WEIGHT MANAGEMENT PROGRAMS *S9449/Dx. Z7189* ☐ HEALTH CLUB/GYM MEMBERSHIP *S9446/Dx. Z7189* ☐ CHILDREN'S FITNESS ACTIVITIES *S9451/Dx. Z7189* PROVIDED BY: ____________	$ ________

SECTION 4
SIGNATURE AND DATE *Unsigned forms will be returned*

I CERTIFY THAT THE INFORMATION SUBMITTED IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE. THE EXPENSES INCURRED WERE FOR MYSELF, SPOUSE, OR QUALIFIED DEPENDENT(S), AND THAT THESE EXPENSES ARE NOT REIMBURSABLE UNDER ANY OTHER HEALTH PLAN COVERAGE.

SUBSCRIBER SIGNATURE: ______________________________ **DATE:** ______________

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information, or conceals information concerning any fact material thereto, for the purpose of misleading, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed $5,000 and the stated value of each violation.