Kansas City

SUBMIT A CLAIM

Please Print or Type

We aim to accurately process your claim in 30 business days. If we need more information, we will attempt to reach you by phone and email. If you have questions, please contact Customer Service at the number listed on your member ID card.

All fields on this page are required unless noted as optional.

Patient Information – Who received care?

All fields in this section are required.

Patient Name _____

Blue KC Member ID _____ (PREFIX) _____ (ID NUMBER) _____ (SUFFIX)

Blue KC Group ID _____ Patient Date of Birth _____

Patient's Relationship to Policyholder: ☐ Self ☐ Spouse ☐ Child

Gender: ☐ Male ☐ Female ☐ Prefer Not To Answer

Policyholder Information

Policyholder Name _____

Street Address _____

City _____ State _____ ZIP Code _____

Healthcare Provider Information (Rendering Provider)

All fields in this section are required unless noted as optional.

Provider's Full Name _____
The name of the individual who rendered or delivered care.

Provider Tax ID _____
This is required. If you need help, ask your healthcare provider for their Tax ID.

Provider NPI _____
This is required. If you need help, ask your healthcare provider for their NPI number.

Phone Number _____

Street Address _____

City _____ State _____ ZIP Code _____

Attach Itemized Receipt(s) from Your Healthcare Provider

Ask your provider for an itemized receipt, which provides proof of the care received. This document(s) is required and must include the following: provider name, provider Tax ID, provider NPI, date(s) of service, the amount charged, a diagnosis code, a procedure code, and a place of service. For your request to be honored, work with your provider to make sure all required information is included.

Claim Details

All fields in this section are required unless noted as optional.

Place of Service

☐ Ambulance ☐ Home Health Visit ☐ Hospital Visit (inpatient) ☐ Hospital Visit (outpatient)

☐ Medical Equipment ☐ Office Visit ☐ Telehealth or Video Call ☐ Urgent Care ☐ Other

Describe the illness or injury for which the patient received care

Total Charges _____ Amount Paid By You _____

Additional Questions

Is the illness or injury connected to the patient's employment? ☐ Yes ☐ No

Does the patient have other group coverage? ☐ Yes ☐ No

If yes, please provide:

Name of Insurance Co. _____ ID Number _____

Group Number _____ Amount Paid by Other Insurance Co. _____

Please attach a copy of the Explanation of Benefits.

Provide Your Contact Information

Email Address _____ Phone Number _____

Signature _____ Date _____

By submitting this form, you agree that all information provided is accurate to the best of your knowledge. You understand that falsifying or misrepresenting essential information is a serious crime which could lead to fines or imprisonment.

Submit this form along with the itemized statement(s) to the local Blue Cross Blue Shield (BCBS) office. If you are located in the Kansas City area, send to Blue Cross and Blue Shield of Kansas City, P.O. Box 419169, Kansas City, MO 64141-6169. If you are located outside of the Kansas City area, please call the customer service phone number listed on your member ID card to get the address for the nearest BCBS office.