MEMBER REQUEST FOR MEDICAL PAYMENT

Please follow attached instructions.

South Carolina

BlueCross BlueShield of South Carolina is an independent licensee of the Blue Cross and Blue Shield Association

Medicare Advantage

Member Name
(Last) **(First)** **(Middle Initial)**

ID Card Number

Mailing Address

Telephone Number

Description of Items/Services Received (Attach all supporting documentation)

Description of Condition for which Items/Services are Needed

Provider Name and Telephone Number

Provider Address

Other Health Insurance - Company Name

(Please indicate if you have additional insurance to BCBSSC Medicare Advantage and include an EOB)

Other Health Insurance - Policy Number

Other Health Insurance - Policyholder's Name

Other Health Insurance - Address

Please attach an itemized statement from your provider. Mail your completed form to:

BlueCross BlueShield of South Carolina
ATTN: Medicare Advantage
P.O. Box 100191
Columbia, SC 29202-3191

For assistance, call 1-855-204-2744. TTY users should call 711.

Instructions - How to Fill Out this Form

Member Name - Member's name (Last, First, Middle Initial)

ID Card Number - ID card number exactly as it appears on the BlueCross BlueShield of South Carolina Medicare Advantage card

Mailing Address - Member's mailing address

Telephone Number - Member's telephone number

Description of Items/Services Received - Describe the items or services you received. Please include and itemized bill and all supporting documentation that provides the following information:

- -Date of service
- -Place of service
- -Description of illness or injury
- -Description of each surgical or medical service or supply furnished
- -Explanation of Benefits (EOB) for Other Health Insurance (if applicable)
- -Charge for each service
- -Doctor/supplier's name and address
- -Provider/supplier's National Provider Identifier (NPI) if known
- -The ordering and referring Providers' Full Legal Name and address*

* Often, a bill will show the names of several doctors or suppliers. Please indicate the provider who treated you by circling his/her name on the bill

Description of Condition for which Items/Services are Needed - Describe the condition for which you are being treated, this may be a diagnosis

Provider Name and Telephone Number - Name and Telephone Number of the Provider who treated you or the name and phone number of the supplier
Provider Address - Address of Provider or Supplier

Other Health Insurance - Company Name - If you have insurance in addition to BlueCross BlueShield of South Carolina Medicare Advantage, provide the name of the other health insurance company and include the Explanation of Benefits (EOB) from the other health insurance company

Other Health Insurance - Policy Number - Policy number with other health insurance

Other Health Insurance - Policyholder's Name - Name of policyholder with other health insurance

Other Health Insurance - Address - Address for other health insurance company