

**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 an itemized bill and all supporting documentation that provides the following information:

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

\* 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