Regence

PO Box 1106
Lewiston, ID 83501

Uniform Medical Plan

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 ☐ Male ☐ Female	Patient's Relationship to Subscriber: ☐ Self ☐ Spouse OR certified domestic partner (DP) ☐ Dependent	Daytime Phone Number
Subscriber's Last Name		Subscriber's First Name	MI
Group Name **Uniform Medical Plan**		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: ☐ Subscriber ☐ Spouse/DP ☐ Child(ren) ☐ 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)	☐ Active ☐ 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 prior to 5/12/2023 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 understand that after the Public Health Emergency ends on 5/11/2023, over-the-counter COVID-19 tests may not be covered by my plan.

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