BlueCross BlueShield Kansas

# Member Reimbursement Form

This form is used when payment was made directly to your provider.
Please fill out, sign, and mail this form with original receipts to:

BCBSKS Member Correspondence
P.O. Box 211355
Eagan, MN 55121

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|---|---|---|---|---|
| Member ID: (*found on your Blue Cross and Blue Shield of Kansas ID card)* | | | | |
| First Name: | | Last Name: | | |
| Street Address: | | | | |
| City: | | | State: | ZIP code: |
| Date of Birth: | Phone Number: | Date of Service: | Was this Related to an Auto Accident? Yes☐ No☐ | |
| Was this Work Related? Yes☐ No☐ | | Other Health Insurance? Yes☐ No☐ | | |
| Name of other Health Insurance: | | Policy Number: | | |

**In order to process your request, please:**

- Complete one form for each service
- Mail original itemized bill that includes the following:
  - Provider name and NPI
  - Date of service
  - Charge
  - Procedure description and/or code*
  - Diagnosis description and/or code*

  **Doesn't apply for flu shots*
- Please keep a copy of your original bill for your files

| | |
|---|---|
| I certify the above information is true, and the enclosed material is correct and unaltered. | |
| Signature: | Date: |