



Regence

Regence BlueCross BlueShield of Oregon is an Independent Licensee of the Blue Cross and Blue Shield Association

PRESCRIPTION/SUPPLIES AND DURABLE MEDICAL EQUIPMENT REPORT

Thank you for choosing Regence BlueCross BlueShield of Oregon for your health insurance coverage. Use this claim form for any prescription, supplies, and medical equipment reimbursement requests you may have. Please complete a separate form for each family member. **The time limit for filing claims is one year from the date of purchase.**

1. Complete the information below and where indicated on the following pages for each receipt submitted.
2. Write your ID number on the top of each page.
3. Tape your original prescription receipts in the boxes marked for receipts; cash register receipts will not be accepted.
4. Retain copies of receipts for your records. Receipts will not be returned.
5. Sign the completed form where indicated at the bottom of this page and mail to:

Regence BlueCross BlueShield of Oregon
 PO Box 1271 MS C7A
 Portland, OR 97207-1271

6. Additional forms may be obtained on our Web site at www.or.regence.com/ms/memberForms.html or by calling (503) 225-5336 in Portland, or toll-free at 1 (800) 452-7390.

Identification Number (3 letters followed by 9 numbers)					
Patient's Last Name			Patient's First Name		MI
Patient's Date of Birth	Patient's Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Patient's Relationship to Subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse or OR certified domestic partner (DP) <input type="checkbox"/> Dependent		Daytime Phone Number ()	
Subscriber's Last Name			Subscriber's First Name		MI
Subscriber's Address			City	State	ZIP Code
Group Name			Group Number		

OTHER INSURANCE INFORMATION

Are you or ANY family members on this policy covered by other

Medical coverage? Yes No Vision Coverage? Yes No
 Dental coverage? Yes No With Orthodontia? Yes No
 Prescription Coverage? Yes No

If YES, is this coverage Group Individual

Are you or any family members covered by Medicare? Yes No (If YES: Part A Part B Part D)

IF THE ANSWER TO ANY OF THE ABOVE QUESTIONS IS "YES," please complete the section(s) below.

If you have more than 2 additional policies, 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: <input type="checkbox"/> Subscriber <input type="checkbox"/> Spouse/DP <input type="checkbox"/> Child(ren)	If two or more coverage's are available for children of divorced parents, indicate name of person with legal custody.		Numbers that identify you to other group (ID numbers, etc.)	
Subscriber's Employer		<input type="checkbox"/> Active <input type="checkbox"/> Retiree	Effective Date of this Plan	

If paid in cash, please indicate why _____

I hereby certify that all information given is correct and receipts are attached. I further certify that all items were purchased for the family member named.

Signature (Subscriber or Patient) _____

Date _____

ID Number _____

Prescription (Rx) receipts must contain:

Rx Number
Date Rx was Filled
Provider's Name
Prescription Medication Name and NDC #
Quantity and Days Supply
Charge

TAPE RECEIPT HERE
In date order

Nature of Illness/Injury

Prescribing Dr.'s Name
(If not on receipt)

If Injury, Date Occurred

How, When, Where

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