BlueCross BlueShield of North Carolina

Experience Health Medicare Advantage (HMO)
Member-Submitted Claim Form

You can use this form for:	You cannot use this form for:
✓ Medical Claims ✓ Supplemental Dental Claims ✓ Vision Claims	× Part D (Drug) Claims (Click here for the Part D form)

Use this form to request reimbursement for covered medical, vision or dental services that you paid for and were not billed to Experience Health Medicare Advantage (HMO) by your provider.

To determine if service is covered, please call Customer Service at 1-833-777-7394 TTY: 711, 7 days a week, 8:00 am to 8:00 pm. The yearly maximum allowance for supplemental dental or vision services can be found in your Evidence of Coverage (EOC).

To be reimbursed for covered services that you paid for in full, you must:

- Complete this form.
- Attach itemized bill from provider.
- Attach paid receipts.

Member's Name:		
Member's ID Number:	Date of Birth:	
Member's Address:		
City:	State:	Zip:
Signature:		Date:

Before mailing, check these things: ✓ Print or type using blue or black ink. ✓ Include all documentation. ✓ Make a copy of the documentation that you send to us for your records. ✓ Submit claims within 12 months of the date of service.	Send the completed claim form and all required documentation to: Experience Health Medicare Advantage (HMO) Attention: Claims Dept. PO Box 3633 Durham, NC 27702