Baylor Scott & White Health Plan

MEDICAL CLAIM FORM

This form is for submission of claims expenses incurred outside of your HMO provider network in the case of urgent or emergency care. Any reimbursement offered to members will be at the Usual and Customary rate and may not match the amount you paid your provider.

This form is not for in-network services that would be filed by a contracted network provider. Network providers are required to submit claims on your behalf.

For the fastest response, send this form to Customer Service securely through the member portal. You may also mail it to us using the address at the bottom of this form. NOTE: Information submitted in non-English languages will be accepted; however, reimbursement may be delayed due to necessary translation. Incomplete forms may be rejected. The limitations, exclusion and timelines of your benefit plan will apply.

Member ID Number: _____

Insured's Name: _____ Group Number: _____
Last First M.I.

Insured's Address: _____
Street City State Zip

Home Phone: _____ Work Phone: _____

Patient Name: _____ Patient Birth Date: _____
Last First M.I.

Relationship to Insured:

☐ Insured ☐ Spouse ☐ Dependent ☐ Other: _____

Date of Service: _____ Provider: _____

Were you on board a cruise ship? ☐ Yes ☐ No

Please check the physical location of the cruise ship at time of treatment:

☐ Outside US territorial waters, OR ☐ Within US territorial waters

If within US territorial waters please provide closest port or city _____ OR the number of hours to the closest US port/city _____ hours

☐ Pay to Member ☐ Pay to Provider ***(must submit unassigned claim form from provider)***

For member reimbursement attach:

Detailed claim from provider or "super bill" that includes the following: Name of the member that received the service; name of subscriber; member number; date of service; amount of charges per service or line item (not as total); amount member paid; Current Procedural Terminology codes (description of service is acceptable); Diagnosis/DX codes (description of service is acceptable); name of any medication and amount of medication administered (description of service is acceptable); provider name; provider address; provider National Provider Identifier (NPI); provider tax ID number (TIN). Please also include copies of the receipts, charges, invoices, cash receipts, canceled checks, or credit card receipts. You will need to submit one claim form per provider.

Mail to:

Baylor Scott & White Health Plan
Attn: Pay Me
1206 West Campus Drive
Temple, TX 76502

Send securely:

Through the member portal.
Find yours at Member.BSWHealth.com