

**PLEASE KEEP COPIES OF ALL RECEIPTS SUBMITTED AND/OR ITEMIZE EACH RECEIPT BELOW AND RETAIN THIS PORTION FOR YOUR RECORDS.**

<b>PROVIDER'S NAME</b>	<b>DATE(S) OF SERVICE</b>	<b>AMOUNT</b>
_____	_____	_____
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Please be sure to cut along dotted line and retain this portion for your records.



**BC/BS #**

**NAME:**

**ADDRESS:**

**\*\* IF NECESSARY, PLEASE CORRECT ANY INFORMATION ABOVE. THANK YOU. \*\***

**ANY OTHER BLUE CROSS I.D. NUMBER OR HEALTH INSURANCE POLICY**

\_\_\_\_\_  
*(Name and Number)*

*Please be sure to include your receipts with this portion when submitting your claims*

**\*\*\*\*\* IMPORTANT \*\*\*\*\***  
**DO NOT DISCARD - PLEASE FOLLOW THE INSTRUCTIONS BELOW**

**INSTRUCTIONS:** WHEN YOU ARE READY TO SUBMIT ADDITIONAL RECEIPTS, PLEASE FILL OUT ALL NECESSARY INFORMATION ON THE BACK SIDE. PLEASE BE SURE TO INSERT THIS STUB PORTION INTO THE ENCLOSED ENVELOPE WITH THE ADDRESS BELOW APPEARING THROUGH THE WINDOW WHEN MAILING IN YOUR RECEIPTS.

ATTN MSS - BASIC - 00061  
BLUE CROSS & BLUE SHIELD OF RI  
444 WESTMINSTER STREET  
PROVIDENCE, RI 02903-3279

