Regence
Group Administrators
An Independent Licensee of the Blue Cross and Blue Shield Association Serving Select Counties in Washington

Member Reimbursement Claim Form

Instructions

Please use this form if requesting reimbursement for claims related to all medical, dental, and vision services covered by Regence Group Administrators (RGA), your third-party Health Plan Administrator. For prescription claims, contact your pharmacy benefits manager (PBM). You will need to complete and submit this form only if your health care professional isn't filing the claim for you. Your health care professional can still file the claim for you if they are out-of-network with your policy; however, they are not required to do so.

Please include a copy of your itemized receipt, bill, and/or invoice with your completed claim form. Your submission must contain all necessary information based on the type of service for which you're requesting reimbursement. The minimum necessary information for each type of service is described below in the "Attachments" section.

☐ I understand that my claim for reimbursement might be delayed or even denied if I haven't provided all the information needed to process my claim.

Note: Providers who are contracted with a PPO Network that is accessible and utilized by your Health Plan are contractually required to bill your Plan and be paid directly by the Plan for services they provide to you. If you have received services from a provider who is in your Plan's PPO Network, we will remit payment to the provider, even if you indicate you want reimbursement to go to you. If you have already paid the provider for your care, you will need to contact them to arrange for a refund, if applicable. Moving forward, be sure to provide your providers with your insurance card so they can bill your Plan directly.

Any questions? We are here to help! Contact Customer Care at 866-738-3924.

Submission Information

Please choose one of the following methods below for submitting your claim reimbursement request (pick any option that works for you)**:**

Electronic Submission Options

✓ **Option 1: DocuSign**:

1. Go to https://wa.accessrga.com/news-and-resources/member-forms
2. Scroll to **Member Reimbursement Claim Form** and click **Complete Online**
3. Complete and submit the form and a copy of your itemized receipt, bill, and/or invoice through DocuSign

✓ **Option 2: RGA Member Portal**:

1. Login to the member portal at https://memportal.accessrga.com/login?context=rgawa
2. In the member portal, click on **Manage Claims & Deductibles**, click on **Submit a Claim**, and follow the prompts - be sure to upload a copy of your itemized receipt, bill, and/or invoice

Paper Submission Options

4. Go to https://wa.accessrga.com/news-and-resources/member-forms
1. Scroll to **Member Reimbursement Claim Form** and click **Download pdf**
2. Fill out the form in compatible PDF software like Adobe Reader or Acrobat (it is not recommended to try filling out the form in a web browser or on a mobile device, as the form may not work correctly) or print out the form and fill it out by hand
3. Use one of the submission options below:

   ✓ **Option 1: Fax** the completed form and a copy of your itemized receipt, bill, and/or invoice to: 866-458-5488

   ✓ **Option 2: Mail** the completed form and a copy of your itemized receipt, bill, and/or invoice to:
   RGA
   Attn: Claims Department
   PO Box 52730
   Bellevue, WA 98015-2730

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Patient Information

First Name _____ **Last Name** _____

Date of Birth _____ **Member ID Number**[1] _____

Group/Employer Name _____ **Group Number**[1] _____

Service Type

Please select the type of service for which you're requesting reimbursement. If more than one service type applies, you must submit a separate claim form for each. If you're completing this form electronically, your selection here drives which information will be marked as required in the "Attachments" and "Claim Information" sections below.

Service Type Select...

Attachments

Please include all relevant documentation (such as an itemized receipt, bill, and/or invoice) with your submission. The checkboxes below indicate which information your documentation must contain for each service type. **Failure to provide the requested information may cause your claim to be delayed or denied.**

☐ **Required for all service types:** Date(s) of service and total amount you were billed for each service rendered / equipment purchased

☐ **Required for all service types *except* durable medical equipment (DME) purchased through a store (not purchased through a certified DME vendor):** Patient name, provider full name and mailing address, including city, state, and ZIP code, procedure codes such as CPTs or HCPCs, and one or both of the following: Provider's national provider identifier (NPI) number, provider's tax ID number (TIN)

☐ **Required for all service types *except* DME purchased through a store and massage therapy:** Diagnosis code(s), in ICD format

Claim Information

Please enter all necessary information below or ensure it's listed on the documentation you're attaching with your submission such as an itemized receipt, bill, and/or invoice. **Failure to supply all the required information may cause your claim to be delayed or denied.**

↓ Check each applicable box below if you're including an attachment that contains this information. If so, no need to also write the information below.

☐ **Date(s) of Service**[2] _____

☐ **Total Billed Amount** _____

☐ **Provider Name** _____

☐ **Provider Mailing Address** _____

City _____ **State** _____ **ZIP Code** _____

☐ **Procedure or Service Codes (such as CPTs or HCPCs)**[3] _____

☐ **Diagnosis Codes (in ICD format)**[4] _____

☐ **Provider's NPI Number**[5] **and/or Tax ID Number (TIN)**[6] _____

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1 This information can be located on your insurance ID card. "Member ID" is also called "Employee ID".
2 For DME you purchased through a store, this is the purchase date.
3 Procedure/Service Code (CPT/HCPC) is usually a five-digit number that describes the services/products provided.
4 Diagnosis Code (ICD) is usually a three- to seven-character alphanumeric code that indicates the reason for your healthcare treatment.
5 National Provider Identifier (NPI) is a unique 10-digit ID issued to U.S. healthcare providers by the Centers for Medicare and Medicaid Services (CMS). If you don't know your provider's NPI, please contact your provider to obtain it before submitting your claim for reimbursement. If you submit your claim without this information, it might be denied if we're unable to verify your provider.
6 Tax Identification Number (TIN) is a unique 9-digit ID issued by the IRS. If you don't know your provider's TIN, please contact your provider to obtain it before submitting your claim for reimbursement. If you submit your claim without this information, it might be denied if we're unable to verify your provider.

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Accident Information

Is This Claim Due to an Accident? ◯ No (skip to next section) ◯ Yes (fill out this section)

Accident Date _____ **Accident Location** ○ Home ○ Work ○ School ○ Auto ○ Other _____

How Did the Accident Happen? _____

Are You Filing a Claim with Labor & Industries (L&I), Homeowner/Auto Insurance, or Any Other Party? ○ Yes ○ No

Signature

Note: It's a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

By signing below, I indicate the following:

- ☐ I certify that the information I provided on this form is true and complete to the best of my knowledge.
- ☐ I expressly authorize any provider of care to provide Regence Group Administrators with any records concerning me or any member of my family for whom benefits or services have been claimed.
- ☐ I understand that my claim for reimbursement might be delayed or even denied if I haven't provided all the information needed to process my claim.

The signature fields will display once you've checked all three checkboxes directly above indicating you certify the accuracy of your submission, authorize release of information relating to this claim, and understand the submission requirements herein.

Signature _____ **Date** _____