BLUECHOICE HEALTHPLAN
BlueCross BlueShield of South Carolina

Member Claim Form

Patient's Name: _____ Sex: ☐ Male ☐ Female

Patient's Birthdate: _____/_____/_____
MM DD YY

Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured's Name: _____

Insured's ID Number: _____

Patient's Address (No., Street): _____

City: _____ State: _____

ZIP Code: _____ Telephone: (_____)_____

Date(s) of Service From MM DD YY	To MM DD YY	Description of Item or Service	Amount Paid

Provider 's Name: _____

Provider 's Address (No., Street): _____

City: _____ State: _____

ZIP Code: _____ Telephone: (_____)_____

Large Group (51+ employees)
Member Service
800-868-2528
786-8476 (in Columbia)

Carolina Advantage (2-50 employees)
Member Service
866-858-3272
382-5975 (in Columbia)

Claims Address:
BlueChoice HealthPlan
Claims Department
P.O. Box 6170
Columbia, SC 29260-6170