BlueCross BlueShield Nebraska

P.O. Box 3248 | Omaha, NE 68180-0001
Medicare.NebraskaBlue.com

Dental Providers: If you are helping the member complete this form, please send it to P.O. Box 3248 Omaha, NE 68180-0001. Please do not submit a claim to any other BCBSNE address.

Member Application for Medicare Advantage Dental Claim Reimbursement

Print, complete, sign and mail this form along with required documents to P.O. Box 3248, Omaha, NE 68180.

Member ID: The Member ID can be found on your Blue Cross and Blue Shield of Nebraska ID card.

Member ID:

Member Information

Last Name:	First Name:		
Phone:			
Street Address:			
City:	State:	ZIP:	
Date of Birth:	Date of Service:	Total Charge for Date of Service: $	
Provider Name	Provider Tax ID Number:	Provider NPI Number:	
Provider Address:			

To speed up processing of your request, please remember to:

- Complete one form for each date of service.
- Mail or upload original clear itemized bill(s) on the provider's letterhead that includes the following: Date of service, provider name, charge provider, and NPI/TIN

  The dentist office should provide this upon request. Without the information above, we cannot process your claim reimbursement and we will have to return it to you. Cash register receipts, cancelled checks, money orders, and personal itemizations are not accepted as original receipts.
- Keep copies of your documents for your files. We cannot return originals to you.
- **Mail this form and your original documents to the following address:**
  Blue Cross and Blue Shield of Nebraska, P.O. Box 3248 Omaha, NE 68180-0001
- Track the status of your reimbursement in your myNebraskaBlue member portal.

Checks will be mailed to the address on file and will not be sent to the address on this form. If you need to update your address please contact Member Services at 888-488-9850 between 8 a.m. to 9 p.m., Central time, seven days a week from Oct. 1 through March 31; 8 a.m. to 9 p.m., Central time, Monday through Friday April 1 through Sept. 30.

I certify the above information is true, the enclosed material is correct and unaltered, and the expenses were incurred by the enrollee listed above. False receipts or altering of this information will result in civil or criminal prosecution. I authorize the release of any information as described below.

Member's signature:	Date:

Your right to confidentiality: We will not release any information about you unless you ask us to in writing, or when release is necessary to process or review a claim (to another insurance company, for example). We will tell you which information we release and to whom, if you request it.