Medical Record Submission Form

The information you provide will enable Empire BlueCross BlueShield to properly route your Medical Record submission.

If you received a letter requesting your record submission please be sure to include a copy of the letter with your submission. This form SHOULD NOT be used for the first time submission of claims. This form should only be used when submitting medical records for adjudicated claims.

Today's Date

Provider/Facility NPI Provider/Facility Name

Claim Number(s)

Dates of Service/Date Span

Full Patient Identification Number (with prefix)
** Or attach a copy of the insurance card**

Patient Name Policyholder Name

Patient Date of Birth

Reason for Submission

Contact Name and Title (Name of person submitting the records)

Contact Phone Number Number of pages in Medical Records

Are these records submitted in more than one package? ☐ Yes ☐ No

If Yes how many packages were submitted?

SUBMIT TO:
Empire BlueCross BlueShield
P.O. Box 1407
Church Street Station
NY, NY 10008-1407