Blue Cross Blue Shield of Rhode Island

Member Claim Submission Form – Donor Egg and Sperm

Standard Infertility Service Benefits

Member Name : _____ Date of Birth : _____

ID Number : _____ Date of Service : _____

Donor Egg (S4025) : _____ Donor Sperm (S4026) : _____

Name of Egg or Sperm Bank : _____

Address : _____

State : _____ Provider Phone Number : _____

Please attach your receipt and proof of payment to this form. The receipt must include the egg or sperm bank's name and address. The completed form and attachments should be mailed to:

Blue Cross & Blue Shield of Rhode Island
Attention: Claims Department
500 Exchange Street
Providence, RI 02903

Please note: Coverages vary and benefits must be considered/consulted for services such as collection, storage, etc.