MEMBER CLAIM SUBMISSION FORM- Fertility Cycle Tracking App

Please Type or Print

Member Name: Date of Birth:

ID Number: Date of Purchase:

Subscription Terms: (monthly/annually) Price per subscription term:

Name of App Purchased:

☐ Natural Cycles®

☐ Clue Birth Control®

☐

CPT Service Code: **99199**

ICD-10 Code: **Z30.09**

The apps do not require a prescription.

Please attach your receipt and proof of payment to this form. The receipt must include the name of the app, terms of purchase (monthly/annually), amount of payment made.

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