Blue Cross Blue Shield of Rhode Island
500 Exchange Street, Providence, Rhode Island 02903-2699
(401) 459-1000 bcbsri.com

Instructions for requesting reimbursement- Doula Services

Use the Doula Claim Reimbursement Request Form when you have expenses from a doula who did not bill the plan directly. Please view the Summary Plan Description (SPD) for a full description of plan benefits, exclusions, and limitations.

Checklist of required documents

Please include:

- ☐ Proof of payment
- ☐ Reimbursement form including:
  - ☐ Name of patient
  - ☐ Name, address, and IRS/ TAX ID of the provider
  - ☐ Date(s) of Service
  - ☐ Itemized charge for each service received

Next Steps

To help process your claim, the reimbursement form must be fully completed and returned with all required documents. You can mail your forms to the following address:

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

Questions?

Call (401) 459-5000 or 1-800-639-2227 (TTY/TDD: 711)
Monday through Friday, 8:00 a.m. – 8:00 p.m.
Saturday and Sunday, 8:00 a.m. to noon

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This form should be filled out and submitted by the member after services have been rendered

Section A: Member Info

This section can be filled out by the member

Member Name: _____

Date of Birth: _____/_____/_____ **ID Number:** _____

Doula Full Name: _____

Doula Address: _____

_____

Section B: Provider Details

The following information is required if payme *ended for member payments as well.*

The Doula will need to provider the member with their NPI & TAX-ID.

Doula NPI: _____

Doula TAX ID/Social Security #: _____

If the Doula does not have a TAX-ID, the Doula can provider their Social Security number instead.

Section C: Claim Details (include itemized receipt)

Type of Service. Please check all that apply:

Place of Service Please Check One: Home 12 __ Telemedicine 02 or 10 __ Office 11 __ Outpatient Hospital __ Inpatient Hospital 21__

Prenatal Services S9445FP: ___ Diagnosis Code: _____ # of Visits/Units: ____

This means the number of hours spent with the Doula.

Dates of Service(s): ____/____/____ to ____/____/____

Place of Service Please Check One: Home 12 __ Telemedicine 02 or 10 __ Office 11 __ Outpatient Hospital __ Inpatient Hospital 21__

Delivery/End of pregnancy S9445XU: __ Diagnosis Code: _____

Doula should provider member with diagnosis code for service

Dates of Service(s): ____/____/____ to ____/____/____

Place of Service Please Check One: Home 12 __ Telemedicine 02 or 10 __ Office 11 __ Outpatient Hospital __ Inpatient Hospital 21__

Postnatal Services S9445TH: __ Diagnosis Code: _____ # of Visits/Units: _____ Total: $_____

Dates of Service(s): ____/____/____ to ____/____/____

Total ALL: $_____

Check what Place of Service your service was rendered

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Section A: Member Info

Member Name: _____

Date of Birth: _____/_____/_____ **ID Number:** _____

Doula Full Name: _____

Doula Address: _____

_____

Section B: Provider Details

The following information is required if payment direction is to the doula/provider and is recommended for member payments as well.

Doula NPI: _____ *** required field**

Doula TAX ID/Social Security #: _____

Section C: Claim Details (include itemized receipt)

Type of Service. Please check all that apply:

Place of Service Please Check One: Home 12 __ Telemedicine 02 or 10 __ Office 11 __ Outpatient Hospital __ Inpatient Hospital 21__

Prenatal Services S9445FP: ___ Diagnosis Code: _____ # of Visits/Units: _____ Total: $_____

Dates of Service(s): _____/_____/_____ to _____/_____/_____

Place of Service Please Check One: Home 12 __ Telemedicine 02 or 10 __ Office 11 __ Outpatient Hospital __ Inpatient Hospital 21__

Delivery/End of pregnancy S9445XU: __ Diagnosis Code: _____# of Visits/Units: ____Total: $_____

Dates of Service(s): _____/_____/_____ to _____/_____/_____

Place of Service Please Check One: Home 12 __ Telemedicine 02 or 10 __ Office 11 __ Outpatient Hospital __ Inpatient Hospital 21__

Postnatal Services S9445TH: __ Diagnosis Code: _____ # of Visits/Units: _____ Total: $_____

Dates of Service(s): _____/_____/_____ to _____/_____/_____

Total ALL: $_____

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