Blue Cross Blue Shield of Rhode Island

Member Claim Submission Form
Expanded Fertility Services: Cell Shipping

Reimbursement Explanation: Cell shipping is covered up to a $1,000 lifetime limit per member. Cell shipping coverage includes shipping donor egg and sperm, or member's own oocytes (eggs), embryos, and sperm shipped for infertility treatment or elective purposes. If utilizing and shipping donor cells, members must be diagnosed with infertility by a licensed healthcare provider and sign the below attestation.

Please note, coverage benefits may vary between groups/contracts. Refer to the appropriate Subscriber Agreement or Benefit Booklet for applicable coverage.

Member Information and Date of Shipment:

Member Name: _____ Date of Birth: _____

ID Number: _____ Date of Shipment: _____

Shipping Information – Shipped To:

- Fill in the facility name and information where the specimen was shipped to.
- If the specimen was shipped directly to the member, leave the facility/clinic name blank and list member's home address and phone number.

Name of Storage Facility / Clinic: _____

Address: _____

State: _____ Phone Number: _____

Submission Instructions:

Attach your proof of payment to this form. Acceptable proof of payment includes a shipping invoice/receipt from the storage facility **or** a UPS, FedEx, or other shipping service receipt.

- Receipt must include facility name (if applicable), address, and date of shipping. Receipt information must match the information provided above.

- Shipping fee amount paid should be clearly and independently stated.

Please mail the completed form and attachments to the address below. This form can also be completed and submitted electronically via the member portal.

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

Infertility Attestation:

If shipping donor cells (donor egg or sperm), please complete the below attestation. If you are **not** shipping donor cells, **leave the below attestation blank**.

> With the below signature, I attest that I am requesting reimbursement for donor eggs or donor sperm that are for treatment of infertility as diagnosed by a licensed healthcare provider. I further attest that the information provided in support of this submission is complete and correct.
>
> Member signature: _____