

## Member Claim Submission Form

### Expanded Fertility Services: Cell Storage

**Reimbursement Explanation:** Cell storage fees are covered up to 12 months per member per benefit year. Members can submit reimbursement for fees related to month-to-month storage, multi-month packages, or once-annual storage in a given benefit year. Multi-year storage claims, or any claim for over 12 months of storage, are not eligible for reimbursement. Cell storage coverage includes storage for donor egg and sperm, or member's own oocytes (eggs), embryos, and sperm stored for infertility treatment or elective purposes. If utilizing and storing 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 Storage Date:

Member Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

ID Number: \_\_\_\_\_ Date of Service (Storage Start Date): \_\_\_\_\_

#### Select Cell Type in Storage and List Dollar Amount Paid:

Egg / Oocyte Storage: , \$ \_\_\_\_\_ Sperm Storage: , \$ \_\_\_\_\_

Embryo Storage: , \$ \_\_\_\_\_ Storage Length: Months \_\_\_\_\_

#### Storage Facility Information:

Name of Storage Facility / Clinic: \_\_\_\_\_

Facility / Clinic Address: \_\_\_\_\_

Facility / Clinic State: \_\_\_\_\_ Facility / Clinic Phone Number: \_\_\_\_\_

#### Submission Instructions:

Attach your proof of payment to this form. Acceptable proof of payment includes a storage invoice/receipt from the facility listed above.

- Receipt must include facility name, address, and date of service. Receipt information must match the information provided above.
- Storage 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 storing donor cells (donor egg or sperm), please complete the below attestation. If you are **not** storing 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: \_\_\_\_\_