Blue Cross Blue Shield of Rhode Island

Oral Enteral Food Products Reimbursement Form

Please attach all original, itemized receipts for purchase of oral enteral food products. Highlight or circle the purchased items on the receipt. To receive reimbursement, you must individually list the products purchased on the table below. Then mail this completed form and all itemized receipts to:

BCBSRI Claims Department
500 Exchange Street
Providence, RI 02903-2699

Remember to keep a copy of the receipts for your records.

Date_____

PATIENT INFORMATION

Name_____ BCBSRI Member ID_____

Date of Birth_____ Phone Number_____

Address_____

PROVIDER INFORMATION

Name_____ Phone Number_____

Medical Diagnoses Received from Provider – Provide ICD-10-CM Code(s)
This information can be found on the Preauthorization Form completed by your provider.

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LIST OF PRODUCTS FOR REIMBURSEMENT

Date of Purchase	Product Name Please circle or highlight the item on the accompanying receipt(s).	Price Paid	Line Total *Example*: For 5 low protein bars at $2/bar, enter $10.
		TOTAL	

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