Blue Cross Blue Shield of Rhode Island

Member Claim Submission Form – Donor Egg and Sperm

Please Type or Print

Member Name : ____________________ Date of Birth : ____________________

ID Number : ____________________ Date of Service : ____________________

Donor Egg (S4025) : ____________________ Donor Sperm (S4026) : ____________________

Name of Egg or Sperm Bank : ____

Address : ____

State : ____________________ Provider Phone Number : ____________________

Please attach your receipt and proof of payment to this form. The receipt must include the egg or sperm bank's name and address. 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

Please note: The donor stipend and the fee associated with storage are excluded from coverage.

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