

## 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.