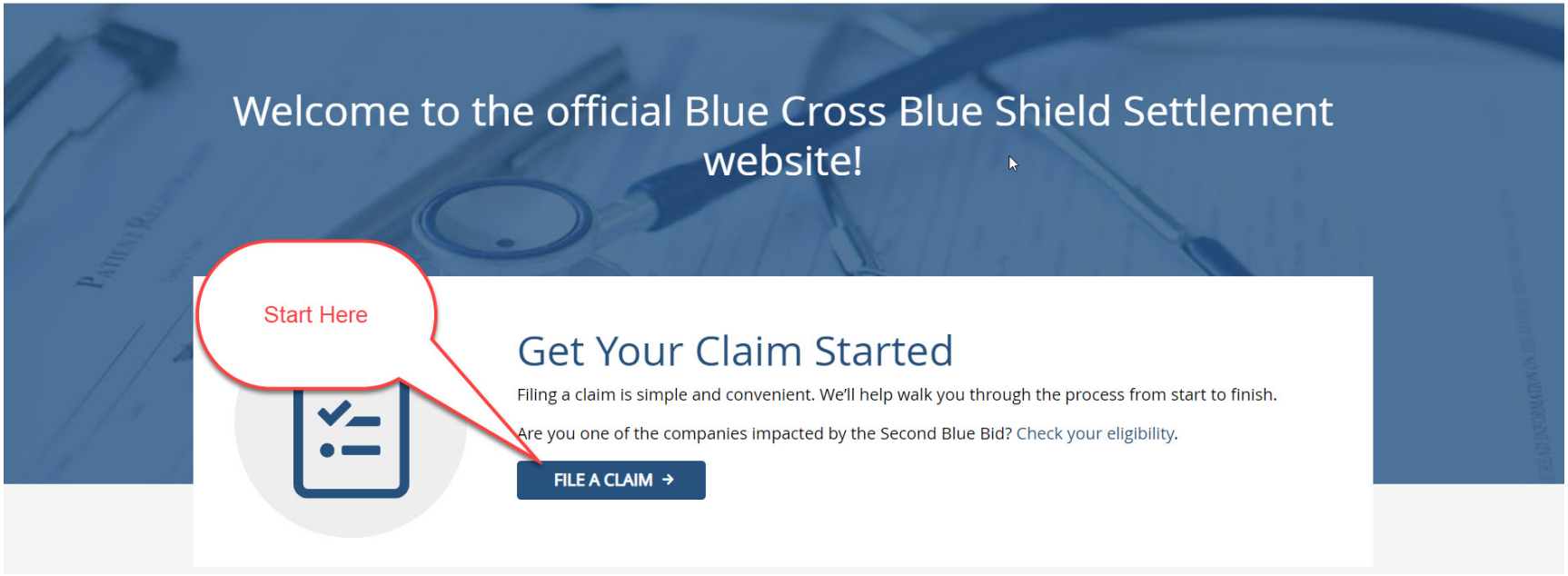
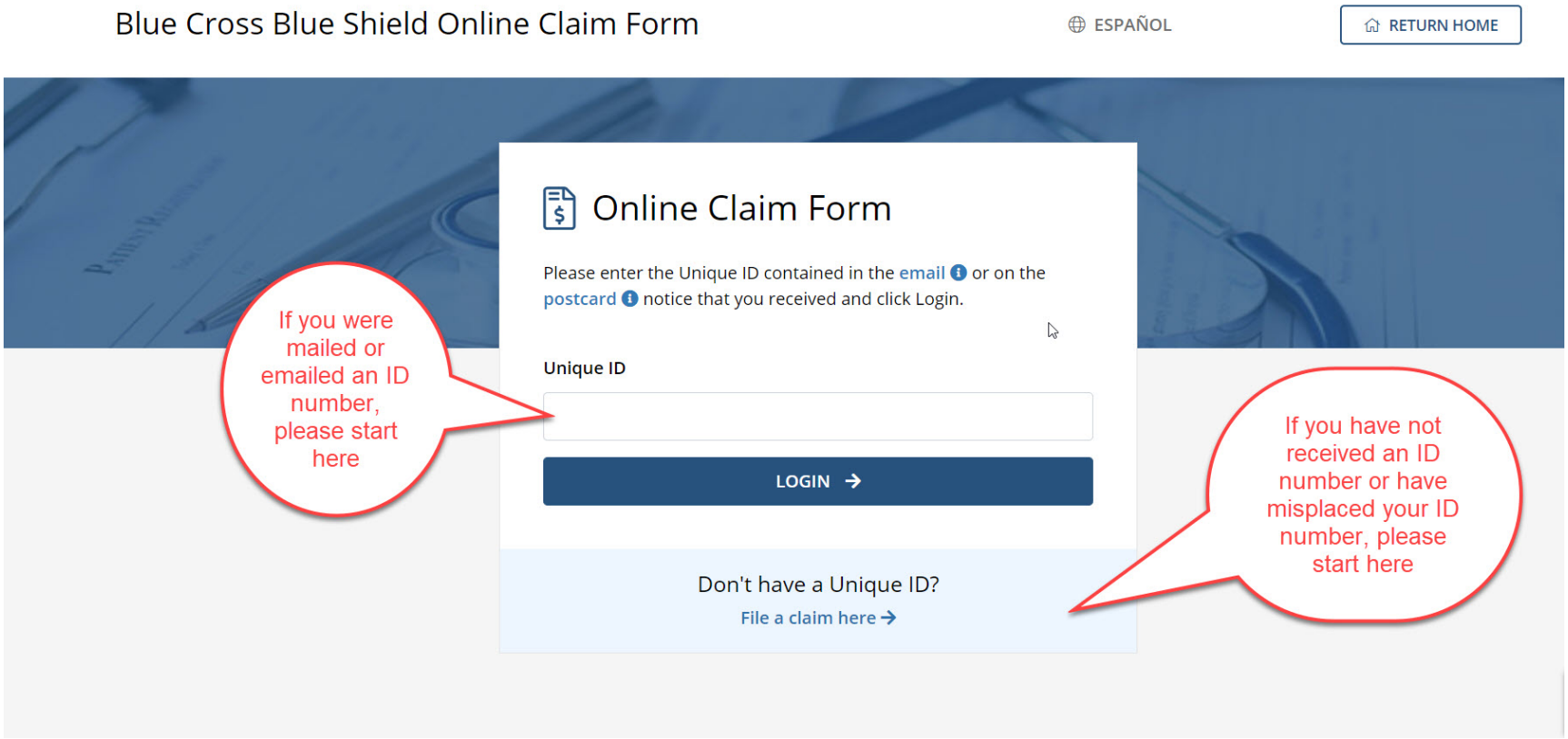
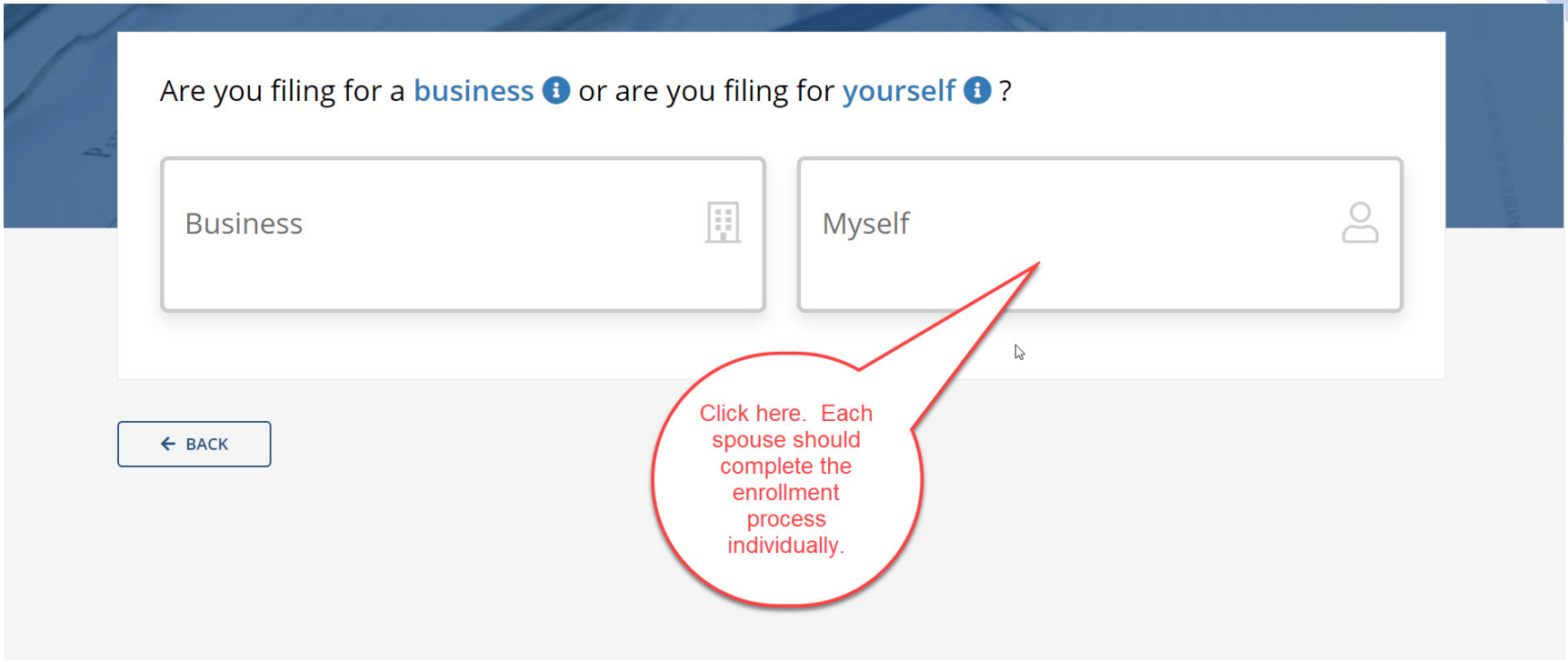
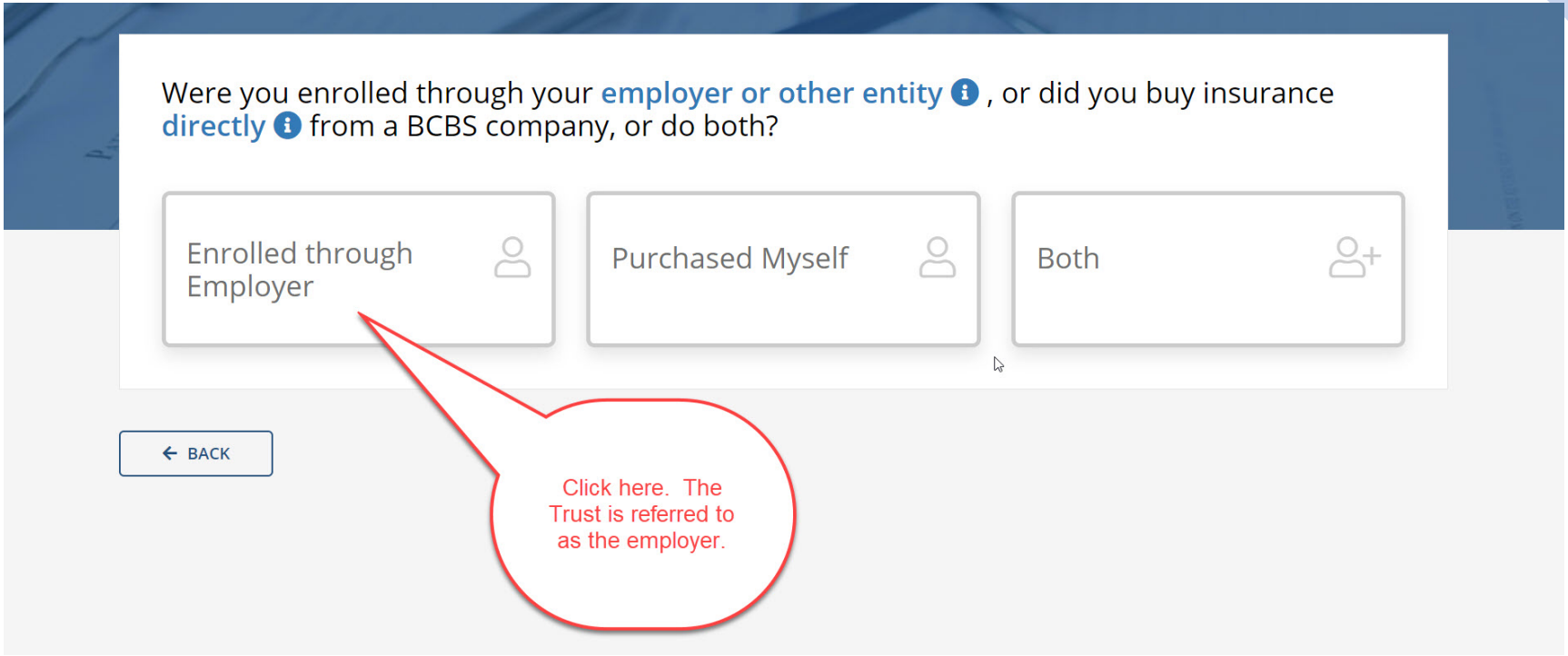
Blue Cross Blue Shield Settlement Website

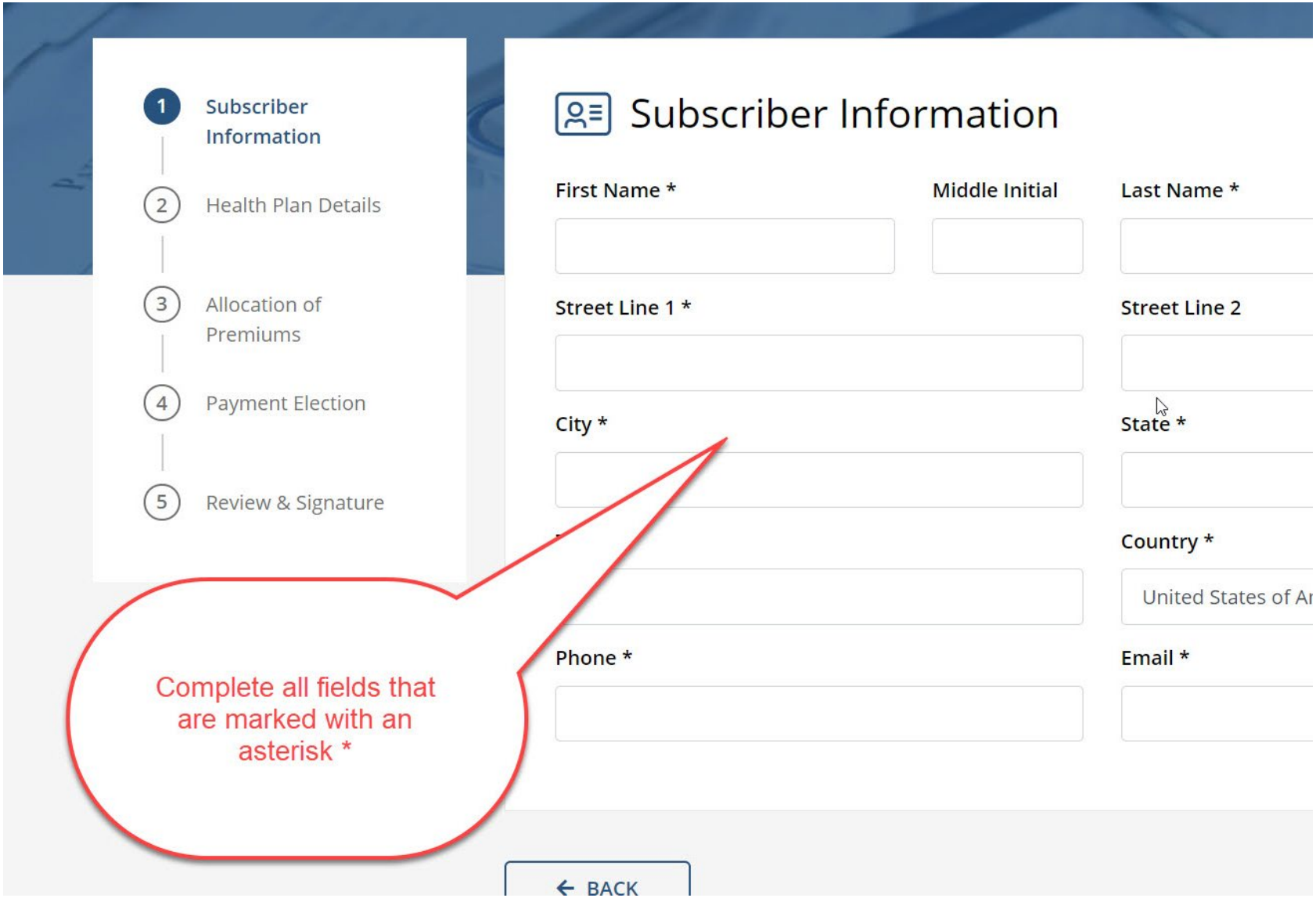
HOME KEY DATES IMPORTANT DOCUMENTS FAQS I WOULD LIKE TO ESPAÑOL

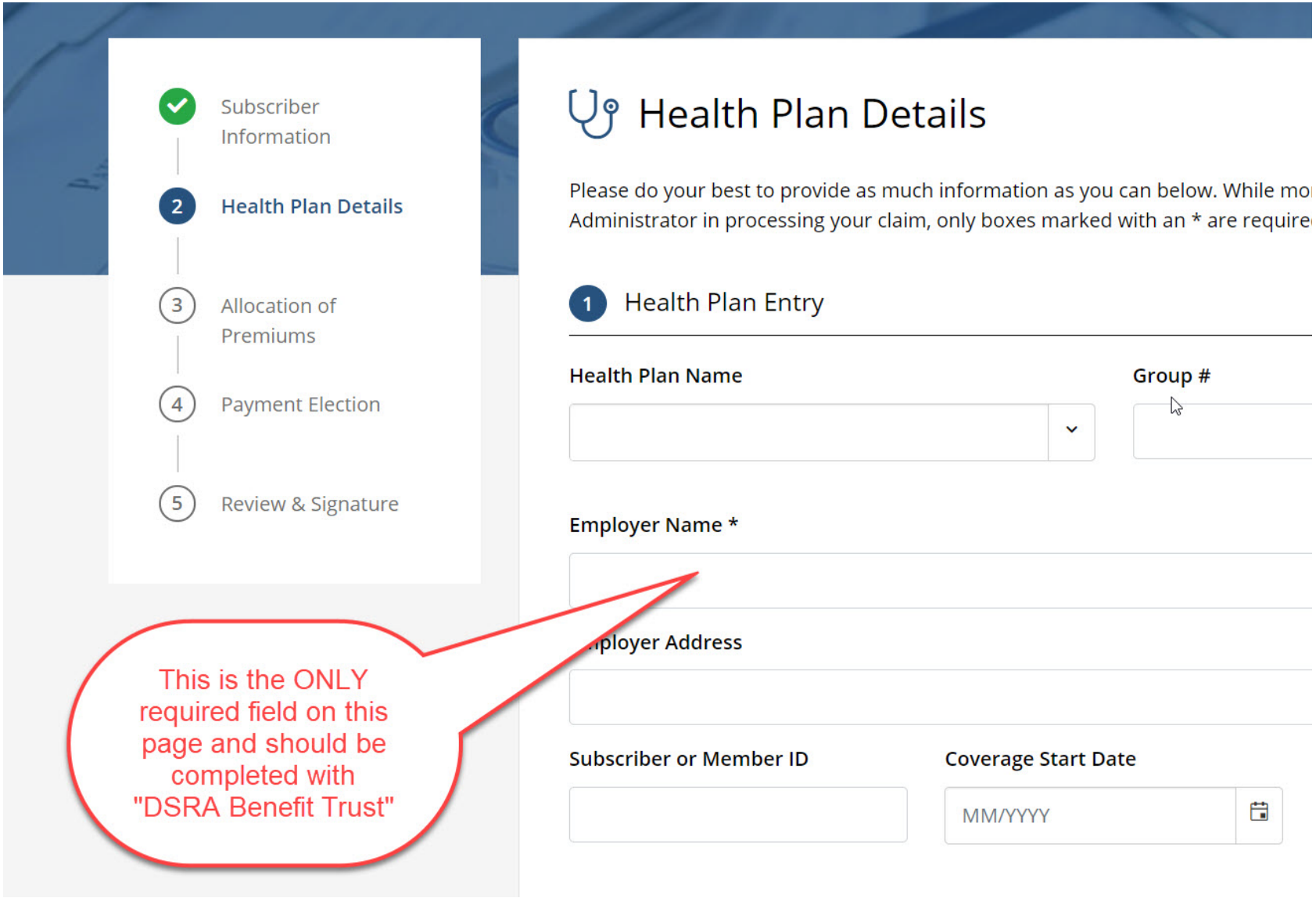


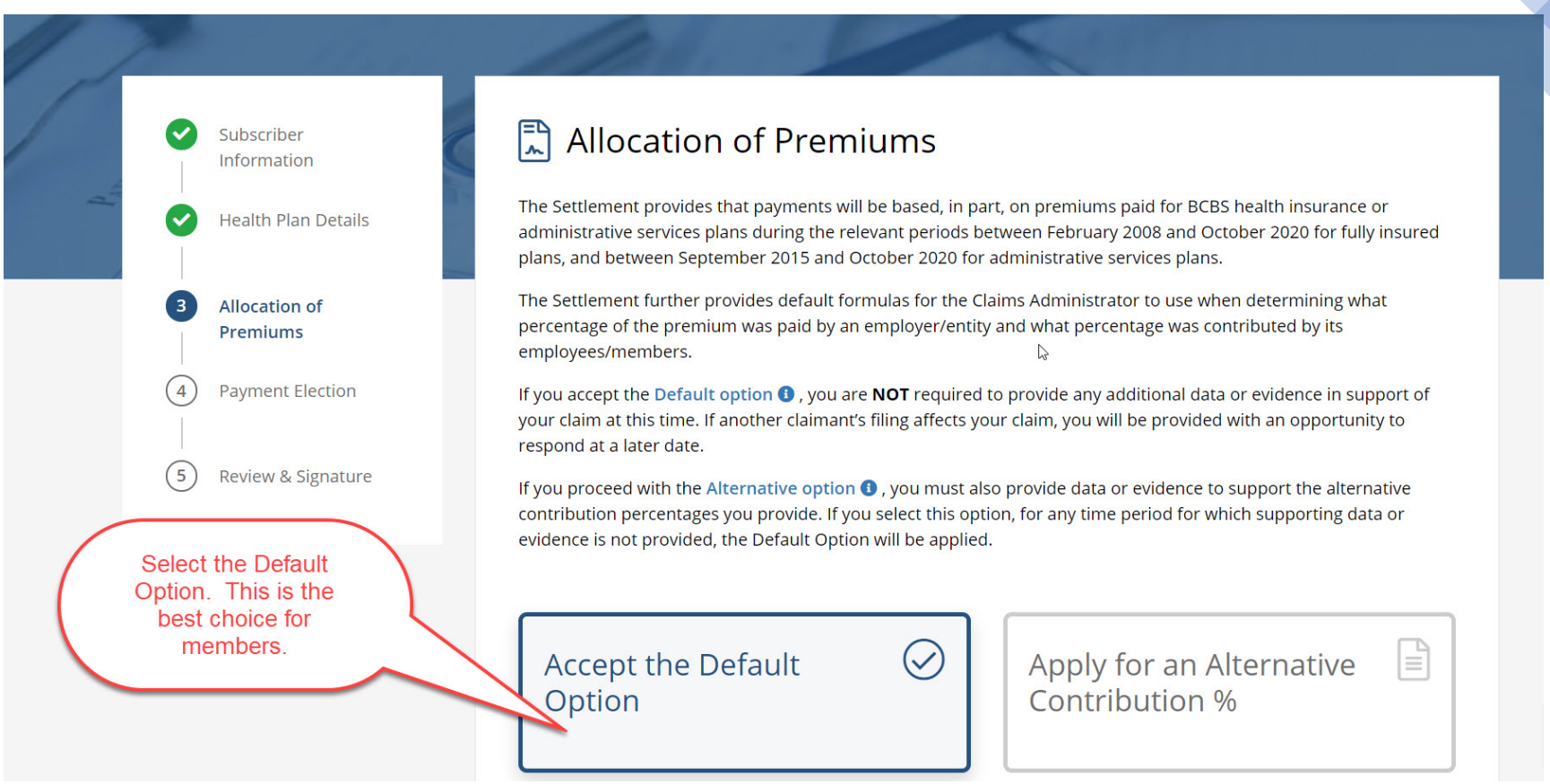

Blue Cross Blue Shield Online Claim Form
ESPAÑOL
RETURN HOME
Online Claim Form
Please enter the Unique ID contained in the email or on the postcard notice that you received and click Login.
Unique ID
LOGIN
Don't have a Unique ID?
File a claim here
If you were mailed or emailed an ID number, please start here
If you have not received an ID number or have misplaced your ID number, please start here


Are you filing for a business or are you filing for yourself ?
Business
Myself
BACK
Click here. Each spouse should complete the enrollment process individually.


Were you enrolled through your employer or other entity , or did you buy insurance directly from a BCBS company, or do both?
Enrolled through Employer
Purchased Myself
Both
BACK
Click here. The Trust is referred to as the employer.


1 Subscriber Information
2 Health Plan Details
3 Allocation of Premiums
4 Payment Election
5 Review & Signature
Subscriber Information
First Name *
Middle Initial
Last Name *
Street Line 1 *
Street Line 2
City *
State *
Country *
United States of Ar
Phone *
Email *
Complete all fields that are marked with an asterisk *
BACK


Subscriber Information
2
Health Plan Details
3
Allocation of Premiums
4
Payment Election
5
Review & Signature
Health Plan Details
Please do your best to provide as much information as you can below. While mo
Administrator in processing your claim, only boxes marked with an * are require
1
Health Plan Entry
Health Plan Name
Group #
Employer Name *
Subscriber or Member ID
Coverage Start Date
MM/YYYY
This is the ONLY required field on this page and should be completed with "DSRA Benefit Trust"


Subscriber Information
Health Plan Details
3
Allocation of Premiums
4
Payment Election
5
Review & Signature
Allocation of Premiums
The Settlement provides that payments will be based, in part, on premiums paid for BCBS health insurance or administrative services plans during the relevant periods between February 2008 and October 2020 for fully insured plans, and between September 2015 and October 2020 for administrative services plans.
The Settlement further provides default formulas for the Claims Administrator to use when determining what percentage of the premium was paid by an employer/entity and what percentage was contributed by its employees/members.
If you accept the Default option , you are NOT required to provide any additional data or evidence in support of your claim at this time. If another claimant's filing affects your claim, you will be provided with an opportunity to respond at a later date.
If you proceed with the Alternative option , you must also provide data or evidence to support the alternative contribution percentages you provide. If you select this option, for any time period for which supporting data or evidence is not provided, the Default Option will be applied.
Select the Default Option. This is the best choice for members.
Accept the Default Option
Apply for an Alternative Contribution %

Payment Election

Please let us know how you would like to receive your settlement payment if your claim is deemed valid.

Final determinations of claim amounts will not be made until after processing by the Claims Administrator is complete. Claims will not be paid if the value is equal to or less than $5.00.

Claimants who submit valid, approved claims shall receive a pro-rata percentage of the Net Settlement Fund allocated to their type of coverage (fully-insured or self-funded) based upon their estimated proportion of the cumulative total of premiums and/or administrative fees paid by all claimants.

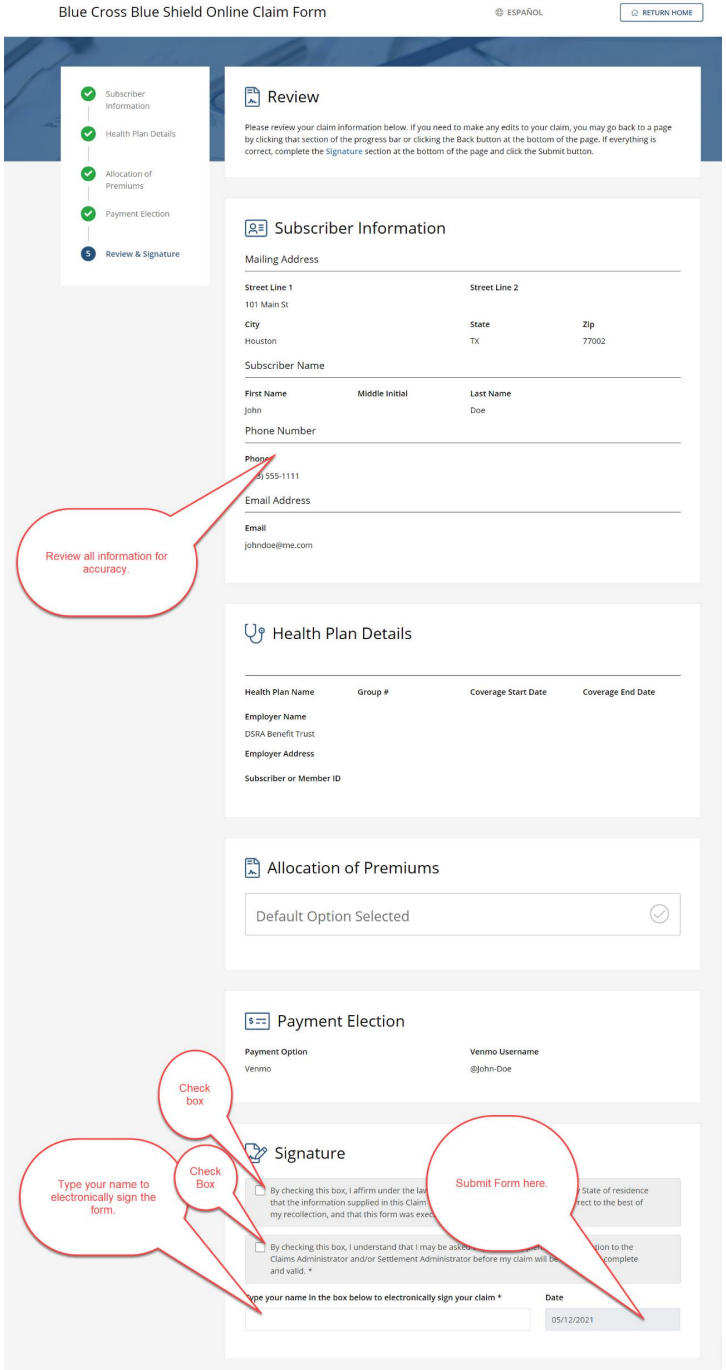
Payment Option *

Please Select

Choose the type of account you wish to receive any settlement monies into and input the account information.

← BACK

NEXT →


Blue Cross Blue Shield Online Claim Form
ESPAÑOL
RETURN HOME
Subscriber Information
Health Plan Details
Allocation of Premiums
Payment Election
5 Review & Signature
Review
Please review your claim information below. If you need to make any edits to your claim, you may go back to a page by clicking that section of the progress bar or clicking the Back button at the bottom of the page. If everything is correct, complete the Signature section at the bottom of the page and click the Submit button.
Subscriber Information
Mailing Address
Street Line 1
101 Main St
Street Line 2
City
Houston
State
TX
Zip
77002
Subscriber Name
First Name
John
Middle Initial
Last Name
Doe
Phone Number
555-1111
Email Address
Email
johndoe@me.com
Review all information for accuracy.
Health Plan Details
Health Plan Name
Group #
Coverage Start Date
Coverage End Date
Employer Name
DSRA Benefit Trust
Employer Address
Subscriber or Member ID
Allocation of Premiums
Default Option Selected
Payment Election
Payment Option
Venmo
Venmo Username
@John-Doe
Check box
Signature
Type your name to electronically sign the form.
Check Box
Submit Form here.
Type your name in the box below to electronically sign your claim *
Date
05/12/2021

Confirmation

Your claim form has been submitted successfully. Please keep the Claim Number below for your records.

Claim Number: PST5Z-JMPLW

You will receive a Claim Number once you have submitted your form. Write this number down.