BlueCross BlueShield of Illinois

Doula Claim Reimbursement Request Form
Request to Reimburse Covered Member

MEMBER SECTION (to be completed by the patient)

Use the Doula Claim Reimbursement Request Form when you have expenses from a doula who did not bill the plan directly. Please ensure the member and doula sections are completed to avoid a delay in processing your claim.

Your doula provider's receipt(s) for service(s) along with this form are required for reimbursement. Each item on this form needs to be completed. Services must be incurred before claim can be paid. Please print or type.

1

Insured/Subscriber Name (Last, First, Middle Initial)	
Mailing Address	
City and State	**ZIP Code**

2

Group No.	**Insured/Subscriber Identification No.** (from ID card)
Patient's Full Name (Last, First, Middle Initial)	
Patient's Gender	**Patient's Date of Birth** Month/Day/Year / /
Patient's Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other (explain) _____	
Patient's Due Date Month/Day/Year / /	

3

Is patient covered under any other health benefits plan (besides Medicaid, Medicare or CHAMPUS)? ☐ **Yes** ☐ **No**	
Insurance Company	**Effective Date of Coverage** / /
Address	**Gender of Insured** ☐ Male ☐ Female
Employer	**Date of Birth of Insured** / /
Insured Name	**Relationship to Patient**
Policy No.	

4

I certify the above is complete and correct and that I am claiming benefits only for charges incurred by the patient named above. Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Patient Signature (or legal guardian)	**Date**	**Daytime Telephone No.**

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DOULA SECTION (to be completed by the doula) Please print or type. **Instructions provided on the following page.**

1

Doula's Name
Doula's Tax ID and NPI (if applicable):
Doula's Certifying Agency:
Doula's Certification Number:
Doula's Address/City/State/ZIP Code:
Doula's Phone Number:
OBGYN and/or Midwife Name and Phone Number:

2

Describe Diagnosis (diagnosis code may be used)
1. Z32.2 Encounter for childbirth instruction (required)

2.

3.

Date of Service MM/DD/YY – MM/DD/YY	Place of Service	Procedure Code (required)	Fee
		T1032 Services performed by a doula birth worker, per diem	
		T1032 Services performed by a doula birth worker, per diem	
		T1032 Services performed by a doula birth worker, per diem	
		T1033 Services performed by a doula birth worker, per diem	

Total charge for ALL covered services $

3

Signature of Doula including degrees or credentials. I certify the above is complete and correct and that I am claiming benefits only for charges incurred by the patient named above. Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Signature	Date

4

SUBMIT THIS COMPLETED FORM WITH ITEMIZED BILLS AND YOUR DOULA PROVIDER'S RECEIPT(S).

Submit the claim online by sending a secure message through Blue Access for Members℠ at www.bcbsil.com/boeing:

SUBMITTING A CLAIM

- Log in to Blue Access for Members with username and password
- Click on 'Messages' on the top right-hand corner of the screen
- Select 'New Messages' on the left-hand side of Message Center and a new message will appear
- In the 'To' field drop down select Claims Submission Attachment
- In the 'Plan' field select the plan for which you're submitting a claim
- In the 'Subject' field type New Claim Submission
- In the 'Message' field put any other information you want to include about your claim
- Click 'Add Attachment' to attach this claim form and electronic copies of your doula provider's receipt(s)
- Click 'Send' once everything has been completed

For ALL QUESTIONS, call Member Services at 888-802-8776.

HOW TO SUBMIT YOUR CLAIM:

- Make copies of this form as needed. Keep one for an original copy.
- A copy of this form must be completed and included with each request for reimbursement.
- Credit card receipts are not acceptable in absence of original receipts.
- Do not highlight or circle covered items or cross off non-covered items on receipts.
- Cleaning supplies, personal items and/or miscellaneous items ARE NOT covered.
- Keep a copy of the entire claim for your records.
- For a faster return on your claim, please include a printout of your appointments from the facility.

REMEMBER TO OBTAIN YOUR DOULA PROVIDER'S RECEIPT(S). PAYMENT CANNOT BE PROCESSED WITHOUT ORIGINAL RECEIPTS. COMPLETION OF THIS FORM DOES NOT GUARANTEE PAYMENT. (Please allow 30 days for your reimbursement.)

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DOULA INSTRUCTIONS

Doula's Name	Enter the performing doula name.
Doula's Tax ID and NPI (if applicable)	Enter the performing doula 9-digit tax ID and NPI.
Doula's Certifying Agency	Enter the name of the certifying agency: National Black Doulas Association®, DONA International or other certifying agency.
Doula's Certification Number	Doula credential identification number through the National Black Doula Association, DONA International or other certifying agency.
Describe Diagnosis (diagnosis code may be used)	All claims must contain a medically accepted diagnosis. Enter a valid ICD-10-CM or DSM5 diagnosis code (including the fourth and fifth digits if applicable) that describes the principal diagnosis for the services rendered. There can be up to 3 diagnoses indicated. The primary diagnosis Z32.2 is required.
Date Range for Services	Enter the "From" and "To" dates of service in MM/DD/YY (ex: 06/04/04) format. Claim line items can include no more than two dates of service for the same procedure code, unless the days are consecutive, and the units coincide. Date spans are acceptable.
Place of Service	Place of Service Codes Code Definition 11 Office 12 Home 21 Inpatient Hospitalization 22 Outpatient Hospitalization 23 Emergency Room – Hospital 24 Ambulatory Surgical Center 25 Birthing Center/Free Standing 26 Military Treatment Facility 50 Federally Qualified Health Center 71 State or Local Public Health Clinic 72 Rural Health Clinic 87 Place of Employment 99 Other Unlisted Facility
Fee	Enter your usual or customary charge for the service/procedure rendered as indicated on each line.
Signature of Doula and Date	Signature of doula including degree(s) or credentials and date of signature for the doula rendering service. The actual signature, signature stamp or computer-generated signature of the doula is preferable. If you are unable to obtain this, please print the name of the doula in this field.