

Deductible Credit Form

(One form only from each employee and their family)

Please return to:
 Premera Blue Cross
 P.O. Box 91059
 Seattle, WA 98111-9159



DATE (mm/dd/yyyy)	PREMERA MEMBER ID	PREMERA GROUP #
REQUESTOR NAME (please print)		
COMPANY NAME		
COMPANY ADDRESS (city, state, ZIP)		
MEMBER NAME (please print)		
MEMBER ADDRESS (city, state, ZIP)		

- **A FULLY COMPLETED DEDUCTIBLE CREDIT FORM MUST BE RECEIVED WITHIN 60 DAYS OF THE FIRST DAY OF YOUR EMPLOYER'S ORIGINAL EFFECTIVE DATE.**
- **Appropriate documentation is required to process your deductible credit information.**
 Please attach a copy of an **Explanation of Benefits (EOB)** from your previous carrier. This EOB should list deductible dollars for each family member separately, illustrating previous deductible met. Or, you may provide us with a report from your prior carrier that contains the following information: prior carrier name, member name, member date of birth, and amount of medical and/or dental deductible satisfied for the current calendar year for each family member.
- You and your family members will receive credit amounts that were applied toward your deductible on your previous insurance plan toward the deductible on your new plan.
- You must list separately the dollar amount met by each member of your family.

MEMBER'S NAME (List your name and the name of each covered family member)	DATE OF BIRTH (mm/dd/yyyy)	MEDICAL	DENTAL
		DEDUCTIBLE \$ CREDITED THIS YEAR _____	DEDUCTIBLE \$ CREDITED THIS YEAR _____
EMPLOYEE		\$	\$
SPOUSE		\$	\$
CHILD		\$	\$
CHILD		\$	\$
CHILD		\$	\$
OTHER		\$	\$

I certify that the expense information I have provided is true and complete. I have attached required deductible documentation for each member listed on this form.

REQUESTOR SIGNATURE: X

PLEASE SEND THIS FULLY COMPLETED FORM TO THE ADDRESS LISTED ABOVE.

Deductible Credit eligibility rules apply; please call Customer Service if you have questions.