BlueCross BlueShield of Kansas City

P.O. Box 419169
Kansas City, MO 64141-6169

MEMBERSHIP TRANSMITTAL

(Please submit separate transmittals for each group number.)

MONTH _____ NO. _____

GROUP NO. _____ GROUP NAME _____ DATE _____

I. ADDITIONS

	DEPT.	NAME OF APPLICANT (Last, First, M.I.)	REQUESTED EFF. DATE	REASON FOR APPLICATION
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				

II. COVERAGE AND MISCELLANEOUS CHANGES

	DEPT.	LAST NAME/CERTIFICATE NO.	REQUESTED EFF. DATE	REASON FOR CHANGE
1.				
2.				
3.				
4.				
5.				
6.				

III. CANCELLATIONS

	DEPT.	LAST NAME/CERTIFICATE NO.	REQUESTED EFF. DATE	TYPE OF CANCELLATION (CODES)
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				

CANCEL CODES

300 – Emp. Request
399 – Terminated; Direct Bill At Home
311 – Terminated
350 – Deceased (Date)
392 – Cancel HMO (Name of HMO)

FORWARDED BY: _____

(Please Return Identification Cards For All Members Listed in Cancellations)

(There should be an enclosure for each entry in Additions and Changes, except for Department Change.)

Blue Cross and Blue Shield includes Blue-Care, Inc., a subsidiary, and TOTAL HEALTH CARE, an affiliate corporation.

PREPARE IN DUPLICATE – RETAIN ONE COPY

INSTRUCTIONS FOR COMPLETING THE MEMBERSHIP TRANSMITTAL FORM

The Membership Transmittal is to be used as a cover document to forward applications and changes to Blue Cross and Blue Shield, plus provide information on individual cancellations. The form should be prepared in duplicate, with the original forwarded to Blue Cross and Blue Shield. This form should be submitted during the month as transactions occur, or once a month with your current dues payment. It is not necessary to hold the form until a section is filled, enabling you to forward your information during the month.

MONTH: Enter the numeric month of the year in which the transmittal is prepared.

NO.: Enter number to indicate the sequence of each transmittal as prepared in any particular month – beginning with No. 1 each month

EXAMPLE: If this were the second transmittal of transactions prepared during the month of March, the blocks would appear as: Month 03 NO.2.

GROUP NO.: Enter your Group Number as it appears on your bill.

GROUP NAME: Enter your Group Name as it appears on your bill.

DATE: Enter the date the transmittal is forwarded to Blue Cross and Blue Shield.

I. ADDITIONS

Applications must be submitted in accordance with your group's enrollment regulations for new hires, reinstatements, and rehires. An application must be enclosed with this form for each line entry in Section I.

DEPT: If your group is departmentalized for billing purposes, enter the applicable department number for the individual being reported. If your group is not departmentalized, leave this column blank.

NAME: Enter the name in last, first, middle initial order as on the application

REQUESTED EFFECTIVE DATE: Enter the effective date based on your enrollment regulations If this date IS incorrect it will be changed by Blue Cross and Blue Shield.

REASON FOR APPLICATION: Enter the appropriate description such as, new hire; reinstatement, rehire transfer from another location.

II. COVERAGE AND MISCELLANEOUS CHANGES

A form must be attached for each entry in this section indicating changes. An exception would be a department change which does not require accompanying documentation. Other types of changes which would normally be included in this section are:

Changes in membership status (Individual to Family or vice versa)
Name Change
Address Change
Marriage or Divorce
Addition or Deletion of Dependents
Deletion of Partial Coverage
Additional Coverage (i.e., add Dental)

III. CANCELLATIONS

An entry should not be made in this section unless **ALL** coverage billed by Blue Cross and Blue Shield is to be cancelled. If only a portion of coverage is to be cancelled, a form must be submitted and an entry made in Section II.

A separate form is not required to report cancellations. Action will be taken to initiate cancellation based on an entry in Section III of this form. In order to allow us to have sufficient information for proper processing, please use the cancellation codes in Section III to indicate the Type of Cancellation. If a terminating employee desires to continue his/her coverage with no lapse through the Nongroup Blue Cross and Blue Shield Program, enter Code "310" in "Type of Cancellation" column, and provide the current home address in this same column on the next line.

Retroactive changes will not be made without Blue Cross and Blue Shield approval, and retroactive cancellations beyond 60 days will not be allowed unless Blue Cross and Blue Shield is at fault. A retroactive cancellation with an effective date prior to date of service on a paid or pending claim will not be allowed.