Blue Cross and Blue Shield of Minnesota Claim Form
Childbirth Education Class

Pregnancy and Childbirth Education Class Reimbursement Form

1. Blue Cross Member Name _____
2. Blue Cross Member ID Number _____
3. Member Mailing Address to Send Reimbursement:
   Street Address/P.O. Box _____
   City/State/Zip Code _____
4. Name of Provider/Facility _____
5. Date/Date Span of class _____
6. Name of Class _____
7. Name of Instructor _____
8. Reimbursement Amount Requested $ _____

(Receipt for payment such as receipt from provider or cancelled check must be included)

Please complete form and attach receipts. Keep copies for your records.
For questions, call Customer Service toll free at 1-800-509-5310 and select option 1.

Submit this claim form and receipts to:
Blue Cross and Blue Shield of Minnesota
P.O. Box 64338
St. Paul, MN 55164