

**PATIENT INFORMATION**

NAME

LAST                      FIRST                      MIDDLE

DATE OF BIRTH         SEX        RELATIONSHIP TO MEMBER

MO   DAY   YR                      M   F                      SELF   SPOUSE   CHILD

OCCUPATION

EMPLOYER

IS PATIENT COVERED BY MEDICARE?  YES  NO

IF YES, MEDICARE I.D. NUMBER

EFFECTIVE DATES

(HOSP) PART A         (MED) PART B

MO   DAY   YR                      MO   DAY   YR

PATIENT WAS TREATED FOR:

INJURY    ILLNESS    PREGNANCY

DATE OF INJURY, ONSET OF ILLNESS OR PREGNANCY

MO   DAY   YR

WAS CONDITION RELATED TO EMPLOYMENT?  YES  NO

DESCRIBE BRIEFLY PATIENT'S ILLNESS OR INJURY . . . IF INJURY, HOW IT OCCURRED.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**OTHER INSURANCE INFORMATION**

DOES PATIENT HAVE OTHER HEALTH INSURANCE?  YES  NO

POLICY HOLDER NAME

INSURANCE COMPANY NAME AND ADDRESS

EFFECTIVE DATE         POLICY NUMBER

MO   DAY   YR

**MEMBER INFORMATION**

I.D. NUMBER

GROUP NO.  ( )

DAYTIME PHONE NO.

NAME

LAST                      FIRST                      MIDDLE

STREET ADDRESS

CITY  STATE  ZIP

NEW ADDRESS  YES  NO      IF YES, HAVE EMPLOYEE SIGN THIS FORM.

MEMBER'S MARITAL STATUS IF OTHER COVERAGE EXISTS:

SINGLE    MARRIED    LEGALLY SEPARATED    DIVORCED    WIDOWED

**IF MARRIED, PLEASE COMPLETE THE FOLLOWING:**

NAME OF SPOUSE

LAST                      FIRST                      MIDDLE

DATE OF BIRTH         SPOUSE'S SOCIAL SECURITY NUMBER

MO   DAY   YR

IS YOUR SPOUSE EMPLOYED?  YES  NO

IF YES, NAME AND LOCATION OF SPOUSE'S EMPLOYER:

EMPLOYER'S NAME AND ADDRESS

NAME OF SPOUSE'S GROUP HEALTH PLAN

**IF DIVORCED OR LEGALLY SEPARATED, AND CLAIM IS FOR A DEPENDENT CHILD, PLEASE COMPLETE THE FOLLOWING:**

OTHER PARENT'S NAME

LAST                      FIRST                      MIDDLE

ADDRESS

EMPLOYER'S NAME AND ADDRESS

**REFERRING PHYSICIAN**

If the bill is from a Licenced Clinical Social Worker; Marriage, Family and Child Counselor; Audiologist; or Occupational, Physical, Respiratory or Speech Therapist, what is the name of the physician who ordered the service?

Dr. \_\_\_\_\_

**PRESCRIPTION DRUGS - List only medications requiring a written prescription. All pharmacy receipts must be attached.**

PURCHASE DATE	Rx NUMBER	DRUG NAME	DIAGNOSIS	COST
Mo   Day   Yr				
				\$
				\$
				\$
				\$
				\$
				\$
				\$
				\$
				\$

Please read both sides of this form carefully. Use a separate Patient Claim Form for EACH PATIENT. Please PRINT or TYPE. TOTAL \$ \_\_\_\_\_

**YOUR COOPERATION IN COMPLETING ALL ITEMS ON THE CLAIM FORM AND ATTACHING ALL REQUIRED DOCUMENTATION WILL HELP EXPEDITE QUICK AND ACCURATE PROCESSING OF YOUR CLAIM.**

<input type="checkbox"/> TOTAL NUMBER OF BILLS ATTACHED	I certify that the information on this claim form is true and correct to the best of my knowledge. I authorize the release of any medical information necessary to process this claim.
PATIENT'S SIGNATURE (PARENT'S SIGNATURE IF PATIENT IS MINOR) _____	DATE _____

## About This Form

Dear Member:

Usually, all providers of health care will bill us directly for services to you and your enrolled dependents.

This is the preferred procedure—you are not bothered with claim forms, and we often need more details than are ordinarily provided on bills to patients.

But sometimes a physician may not bill us. Or an ambulance company, for example, may send the bill directly to you. In either instance, we have no way of knowing about your claim.

That is why this form was developed. Use it to notify us of any covered health service for which we have not already been billed. You are urged to send us each bill immediately upon receipt.

Please read the instructions about how to use this form. It is for your convenience.

We are happy to serve you.

### How to use this form

- Please complete a separate claim form for each patient.
- Attach original medical bills. We suggest that you keep copies for your records.
- If you are enrolled in Medicare, attach a clear copy of the Explanation of Benefits and the related itemized bill.
- If Anthem Blue Cross is not your prime carrier, please include an Explanation of Benefits from your other carrier.

### When to use this form

- Each time you submit bills, including those for prescription drugs, ambulance services and appliances not usually billed directly to Anthem Blue Cross.
- Do not use those form for bills which are being sent directly to Anthem Blue Cross by hospital, doctor, or laboratory.

### Bills must be itemized

Cancelled check, cash register receipts and non-itemized "balance due" statements cannot be processed. Each itemized bill must include:

1. Name and address of provider (doctor, hospital, laboratory, or pharmacy, ambulance service, etc.)
2. Name of patient
3. Date of service
4. Amount charged for each service
5. Diagnosis or reason for treatment

### ***Write your Group Number and your Anthem Blue Cross ID Number on the face of each bill.***

THE FOLLOWING INFORMATION MUST ALSO BE INCLUDED ON BILLS FOR THESE ITEMS:

#### PRESCRIPTION DRUGS:

- RX number and name of drug

#### REGISTERED AND LICENSED VOCATIONAL NURSES:

- Hours and dates of service
- Location of service (residence or name of hospital)
- Written documentation of physician's referral (must include the state license number, plan of treatment and estimated duration of treatments)

#### PROSTHETIC DEVICES, APPLIANCES OR DURABLE MEDICAL EQUIPMENT:

- Doctor's orders or prescriptions
- Purchase price

#### AMBULANCE

- Pick-up and delivery points
- Number of miles

#### WHERE TO SEND COMPLETED CLAIM FORMS

Mail completed form plus itemized bills to the appropriate address listed on your Anthem Blue Cross ID Card.

#### CLAIM INFORMATION

Claims or benefit questions will be answered by contacting the appropriate Anthem Blue Cross Customer Service office listed on your Anthem Blue Cross ID card.