Medical Claim Form

Please use a separate claim form for each patient and provider. Your cooperation in completing all items on the claim form and attaching all required documentation will help expedite quick and accurate processing. SEE REVERSE SIDE FOR COMPLETE INSTRUCTIONS.

Anthem, BlueCross BlueShield P.O. Box 105187

Atlanta, GA 30348-5187

ECTION 1: PATIENT INFORMAT						
<mark>ist name</mark>		First name				
es the patient have other health	insurance coverage?	Relation to subscriber	Sex Mole	Date of I	birth(MM/DD/	<mark>YYYY</mark>)
Yes 🗌 No		🗆 Self 🛛 Spouse 🗆 Son 🗌	Daughter Male			
me of other health insurance cor	npany Group no.	Employer nar	ne	Policy no		
ECTION 2: SUBSCRIBER INFO	RMATION (on Anthem Blue Cro	oss and Blue Shield ID card)				
ntification no.		Group no.				
st name		First name				
reet address (please include apt.	no	City		State	ZIP code	
eet audress (please fictude apt.	no. <i>)</i>	City		Sidle	ZIP COUE	
me phone no.		Work phone no.		Date of b	oirth (MM/DD/	<mark>YYYY</mark>)
ECTION 3: MEDICAL INFORMA						
here was the service rendered	Physician office Ou Medical equipment supp	tpatient Inpatient Ambulan Ilier Pharmacy Laboratory	Other			
	sult of an accident?	· · ·				No No
las this condition or injury job r	sult of an accident?				Yes	No No No
as this condition or injury job r ave you filed for Workers' Com	sult of an accident?	· · ·			Yes	No
as this condition or injury job r ave you filed for Workers' Com	sult of an accident?	· · ·			Yes	No No
las this condition or injury job r ave you filed for Workers' Com /hen did this injury or accident	sult of an accident?		· · · · · · · · · · · · · · · · · · ·		···· Yes ···· Yes	No No
las this condition or injury job r ave you filed for Workers' Com /hen did this injury or accident	sult of an accident?		· · · · · · · · · · · · · · · · · · ·		···· Yes ···· Yes	No No
las this condition or injury job r ave you filed for Workers' Com /hen did this injury or accident	sult of an accident?		· · · · · · · · · · · · · · · · · · ·		Yes Yes Amou	No No
las this condition or injury job r ave you filed for Workers' Com Ihen did this injury or accident Date of service	sult of an accident?		· · · · · · · · · · · · · · · · · · ·		Yes Yes Amou	No No
las this condition or injury job r ave you filed for Workers' Com /hen did this injury or accident Date of service	sult of an accident? elated? pensation? occur? (MM/DD/YYYY)		Tax ID	Total	Yes Yes Amou	No No
las this condition or injury job r ave you filed for Workers' Com /hen did this injury or accident Date of service	sult of an accident? elated? pensation? occur? (MM/DD/YYYY) Diagnosis code Diagnosis code	Procedure code	Tax ID	Total	Yes Yes Amou	No No
las this condition or injury job r ave you filed for Workers' Com Ihen did this injury or accident Date of service	sult of an accident? elated? pensation? occur? (MM/DD/YYYY) Diagnosis code Diagnosis code	Procedure code	Tax ID Tax ID essed. Each itemized bill m ed for each service le	Total	Yes Yes Amou	No No
las this condition or injury job r ave you filed for Workers' Com l/hen did this injury or accident Date of service LLLS MUST BE ITEMIZED ancelled checks, cash register Name and address of provi (doctor, hospital, laboratory, Name of patient Service provided Date of service	sult of an accident?	ance due" statements cannot be proce Amount charg Diagnosis coc Tax ID	Tax ID Tax ID essed. Each itemized bill m ed for each service le de	Total ust include:	Yes Yes Amou \$ 0.0	No No nt
Vas this condition or injury job r lave you filed for Workers' Com Vhen did this injury or accident Date of service ILLS MUST BE ITEMIZED ancelled checks, cash register Name and address of provi (doctor, hospital, laboratory, Name of patient Service provided Date of service certify that, to the best of my k	sult of an accident?	Procedure code	Tax ID Tax ID essed. Each itemized bill m ed for each service le de	Total ust include:	Yes Yes Amou \$ 0.0	No No nt
Vas this condition or injury job r lave you filed for Workers' Com Vhen did this injury or accident Date of service ILLS MUST BE ITEMIZED ancelled checks, cash register Name and address of provi (doctor, hospital, laboratory, Name of patient Service provided Date of service	sult of an accident?	ance due" statements cannot be proce Amount charg Diagnosis coc Tax ID	Tax ID Tax ID essed. Each itemized bill m ed for each service le de	Total ust include:	Yes Yes Amou \$ 0.0	No No nt

HOW TO USE THIS FORM

Dear Member:

Usually, all providers of health care will bill us 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.

Sometimes, a physician or an ambulance company may not bill us, for example, they may send the bill directly to you. In either instance, we have no way of knowing about your claim. This Medical Claim Form was developed to notify us of any covered health service for which we have not already been billed. Please read the following instructions about how to report Health Care Services.

We are happy to serve you.

SECTION 1: PATIENT INFORMATION

Use this section to identify the patient.

SECTION 2: SUBSCRIBER INFORMATION (on Anthem Blue Cross and Blue Shield ID card)

Use this section to identify the subscriber. Some of this information may be found on your Anthem Blue Cross and Blue Shield card.

SECTION 3: MEDICAL INFORMATION

HEALTH CARE SERVICES: Use this section to report any COVERED health service that has not already been reported to this Anthem Blue Cross and Blue Shield Plan by the provider of service (the physician, clinical, ambulance company, private duty nurse, etc.) Attach itemized bill or photocopy. Please be sure that duplicate bills are not submitted.

If you have questions or need any assistance, please call the number listed on your Member ID card.

Anthem Blue Cross and Blue Shield is the trade name of In Indiana: Anthem Insurance Companies, Inc. In Kentucky: Anthem Health Plans of Kentucky, Inc. In Missouri/excluding 30 counties in the Kansas City area): Right CHOICE® Managed Care, Inc. (RIT), HealthyAlliance® Life Insurance Company (HAUC), and HMO Missouri, Inc. RIT and certain affiliates administer non-HMO benefits underwritten by HALC and HMO benefits underwritten by HALC and the strain affiliates only provide administrative services forself-funded plans and do not underwrite benefits. In Ohio. Community hums are e Company. In Miscouris (Die Cross Baue Shield of Wiscouri) BCC SDM), which underwrites or administers the PPO and indermity policies; and Comparerand BCBSW Collectively, which underwrite or Die Dieles. Independent licensees of the Blue Cross and Blue Shield Association. [®]ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are the registered marks of the Blue Cross and Blue Shield Association.