

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.

SECTION 1: PATIENT INFORMATION

Last name		First name		M.I.
Does the patient have other health insurance coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No		Relation to subscriber <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Son <input type="checkbox"/> Daughter		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
Date of birth (MM/DD/YYYY)		Name of other health insurance company		Group no.
Employer name		Policy no.		

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

Identification no.		Group no.		
Last name		First name		M.I.
Street address (please include apt. no.)		City	State	ZIP code
Home phone no.		Work phone no.		Date of birth (MM/DD/YYYY)

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.

Where was the service rendered? Physician office Outpatient Inpatient Ambulance
 Medical equipment supplier Pharmacy Laboratory Other

Was this medical expense the result of an accident? Yes No

Was this condition or injury job related? Yes No

Have you filed for Workers' Compensation? Yes No

When did this injury or accident occur? (MM/DD/YYYY) _____

Date of service	Diagnosis code	Procedure code	Tax ID	Amount

Total \$ 0.00

BILLS MUST BE ITEMIZED

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

- Name and address of provider (doctor, hospital, laboratory, ambulance service, etc.)
- Amount charged for each service
- Name of patient
- Diagnosis code
- Service provided
- Procedure code
- Date of service
- Tax ID

I certify that, to the best of my knowledge, the information on this Medical Claim Form is true and correct. I authorize the release of any medical information necessary to process this claim.

Signature X	Printed name	Date (MM/DD/YYYY)
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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.