

# Medical Claim Form



Please use a separate claim form for each patient. 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 A. 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"/> M <input type="checkbox"/> F
Name of other health insurance company		Group no.	Employer name	Policy no.

Section B. SUBSCRIBER INFORMATION (on Anthem Blue Cross 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 C. MEDICAL INFORMATION		
<p><b>HEALTH CARE SERVICES:</b> Use this section to report any COVERED health service that has not already been reported to this Anthem Blue Cross Plan by the provider of service (the physician, clinical, ambulance company, private duty nurse, etc.) <b>Attach itemized bill or photocopy.</b> Please be sure that duplicate bills are not submitted.</p>		
Was this medical expense the result of an accident? .....		<input type="checkbox"/> Yes <input type="checkbox"/> No
Was this condition or injury job related? .....		<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you filed for Workers' Compensation? .....		<input type="checkbox"/> Yes <input type="checkbox"/> No
When did this injury or accident occur? (MM/DD/YYYY) ___/___/_____		
Diagnosis code	Procedure code	Tax ID

BILLS MUST BE ITEMIZED	
Cancelled checks, cash register receipts and non-itemized "balance due" statements cannot be processed. Each itemized bill must include:	
<ul style="list-style-type: none"> <li>Name and address of provider (doctor, hospital, laboratory, ambulance service, etc.)</li> <li>Name of patient</li> <li>Service provided</li> <li>Date of service</li> </ul>	<ul style="list-style-type: none"> <li>Amount charged for each service</li> <li>Diagnosis code</li> <li>Procedure code</li> <li>Tax ID</li> </ul>

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 <b>X</b>	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 may not bill us or an ambulance company, 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 A. PATIENT INFORMATION

Use this section to identify the patient.

## SECTION B. SUBSCRIBER INFORMATION (on Anthem Blue Cross card)

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

## SECTION C. MEDICAL INFORMATION: This section pertains to the employee through whose employer your program is obtained

**HEALTH CARE SERVICES:** Use this section to report any COVERED health service that has not already been reported to this Anthem Blue Cross 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.

### MEDICAL CLAIM FORM INSTRUCTIONS:

Please send claims to: P.O. Box 60007, Los Angeles, CA 90060