# **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 INFO	ODMATION							
Last name	First name M.I.							
Luctiumo			THECHAINE					
Does the patient have other	health insurance coverage?	Relation to subs	l scriher		Sex	Date of h		<u> </u> )
□ Yes □ No	-			Male				
Name of other health insurance company Group no.		Employe		Female	Policy no			
Name of other floater floater	aroup no	•	Employe	T Hamo		r oney me	•	
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 ph			 e no.			Date of b	oirth (MM/DD/YYYY)	)
SECTION 3: MEDICAL INFORMATION								
HEALTH CARE SERVICES: I	Jse this section to report any COVER	RED health service	that has not alre	eady been report	ed to this Anthem	Blue Cro	nss and Blue Shield	1
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?								
Was this condition or injury job related?								
Have you filed for Workers' Compensation?								
When did this injury or accident occur? (MM/DD/YYYY)								
Date of service	Diagnosis code	Proc	edure 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     Amount charged for each service								
(doctor, hospital, laboratory, ambulance service, etc.)  • Diagnosis code								
<ul> <li>Name of patient</li> <li>Service provided</li> <li>Procedure code</li> <li>Tax ID</li> </ul>								
• Service provided • Tax ID • Date of service								
	of my knowledge, the information or	n this Madical Clai	m Form is true o	nd correct Lout	noriza the rolesse	of any n	nadical information	
necessary to process this		ıı unə medicai cidi	1 01111 13 11 11 16 1	114 6011661, 1 AUII	101176 1116 1 616426	or any n	iouioai iiilUlliialiUl	1
Signature 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.

### ANA CENTRAL MEDICAL CLAIM FORM INSTRUCTIONS:

Please send claims to: Anthem Blue Cross and Blue Shield PO Box 105187 Atlanta, GA 30348-5187

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