Claim Form



See reverse side before filing your claim.

Section 1: Member information

Section 1: Member information						
Member last name		First name				M.I.
Member identification no. — This is required to process your claim.		Group no.				
Street address		City State			ZIP co	de
Section 2: Patient information				-		
Patient last name		First name				M.I.
Date of birth (MMDDYYYY)		Relationship to subscriber Self Spouse Son Daughter				
Section 3: Diagnosis						
What is the illness or injury?	If accident, give date: Date of accident				(MDDYYYY)	
Section 4: Work-related						
Was this a work-related injury or illness? [☐ Yes ☐ No If yes, complete	the following:				
Employer name						
Street address		City		State	ZIP code	
Section 5: Other group health insur	ance				·	
Is this patient covered by another group he	alth plan? ☐ Yes ☐ No If ye	es, complete the following:				
Policyholder name	Policyholder date of birth O	her insurance company name Policy ID no.		Group no.		
Section 6: Medicare						
Is this patient covered by Medicare?	s □ No If yes, give patient's N	Medicare health insurance claim	no.:			_
☐ Part A — Effective date: ☐ Part D — Effective date: ☐ Part D — Effective date: ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐					(MN	IDDYYYY)
Section 7: Authorization and signat	ure(s) — Required.					
The patient must sign the claim form, auth signature must be that of the patient's pare furnish to Anthem or its designee all record review and evaluation of any claim or servicoverage is under a group contract held by for purposes of utilization review or financity years after the termination of coverage, or be binding upon me, my dependents, my had the action of the service was a service when the service was a service when the service was a service when the service was a	nt or legal guardian. I authorize a ds pertaining to medical history, ces. I authorize Anthem or its des an employer, association, trust f al audit. This authorization shall I the last determination or paymen eirs, executors or administrators.	any health care provider, payor of services rendered, and payment signee to disclose such informationd, union, or similar entity, this become effective immediately, and by Anthem on a claim or service.	f health claims, or some made regarding tion to another post authorization and shall remain in the coverage with the coverage made and shall remain in the coverage with the coverage made and the coverage with the coverage with the coverage and the coverage with th	or governring me or no ayor or se also permit in effect un verage. This	ment agen my depend elf-insurer ts disclosi ntil the lat is authoriz	ncy to dents for : If my ure to them sest of six zation shall
I certify that the above statements are com above named patient.	•		· ·	•		•
Important Fraud Warning Statement: Any for insurance or statement of claim contain fact material thereto, commits a fraudulent and the stated value of the claim for each s	ning any materially false informati insurance act, which is a crime,	ion, or conceals, for the purpose	e of misleading,	informatio	on conceri	ning any
Patient signature or authorized representative				Date (MI	MDDYYYY	')
Member signature X				Date (MI	MDDYYYY	7)

How to request benefits

Use this form to file a claim when your doctor doesn't file the claim for you. You should send this completed claim form as soon as possible after you get care. Check your certificate of coverage for specific deadlines to submit your claim.

- **Step 1:** Complete **all** areas of the *Claim Form* before returning the claim to us. If benefits are to be claimed for more than one family member, a separate claim form must be submitted for each member.
- **Step 2:** Include the itemized bill you got from your doctor. It must include:
 - Name, address, and tax ID number of provider (doctor, hospital, laboratory, ambulance service, etc.)
 - · Name of patient
 - · Service provided
 - · Date of service
 - · Place of service
 - · Amount charged for each service
 - · Diagnosis code
 - · Procedure code

Cancelled checks, cash register receipts and non-itemized "balance due" statements cannot be processed.

- **Step 3:** Sign and date the claim form.
- **Step 4:** Recheck **all** information and submit this form along with a copy of your itemized bill to:

Anthem Blue Cross P.O. Box 1407 Church Street Station New York, New York 10008–1407

Have questions or need help? Give us a call at the Member Services number on your ID card.

You may also use the secure online customer service form at anthembluecross.com.