

Claim Form

See reverse side before filing your claim.



SECTION 1: MEMBER INFORMATION

Member last name	First name	M.I.	
Certificate no. – This number is necessary to process your claim	Group no.		
Street address or R.F.D.	City	State	ZIP code

SECTION 2: PATIENT INFORMATION

Patient last name	First name	M.I.	
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Birthdate (MMDDYYYY)	Relationship to subscriber <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Son <input type="checkbox"/> Daughter	

SECTION 3: DIAGNOSIS

What is the illness or injury requiring treatment?	If accident, give date: →	Date of accident (MMDDYYYY)
--	---------------------------	-----------------------------

SECTION 4: WORK-RELATED

Was this a work-related injury or illness? Yes No If yes, complete the following:

Employer name			
Street address or R.F.D.	City	State	ZIP code

SECTION 5: GROUP HEALTH INSURANCE

Do you have other Group health insurance? Yes No If yes, complete the following:

Other insurance company name	Type of insurance	Policy ID no.	Contract no.	
Street address or R.F.D.	City	State	ZIP code	

SECTION 6: MEDICARE

Are you covered under the Medicare program? Yes No If yes, give patient's Medicare health insurance claim no.: _____

SECTION 7: AUTHORIZATION AND SIGNATURE(S) – REQUIRED

I understand that any health care provider, medically related facility, health care plan, insurance company, or other organization and their representatives having personal health information pertaining to me is permitted to give Anthem Blue Cross and Blue Shield or their agents any and all information, including complete medical history records and (if and pursuant to a separate authorization signed by me as required by federal law) mental health and substance abuse records, for consideration of this claim and as may be permissible thereafter in accordance with applicable law. I certify that the above statements are complete and correct to the best of my knowledge and that I am claiming benefits only for charges incurred by the above named patient.

Patient signature (parent if minor) X	Date (MMDDYYYY)
Member or spouse signature X	Date (MMDDYYYY)

