# Medical Claim Form

Anthem

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? ☐ Yes ☐ No | Relation to subscriber ☐ Self ☐ Spouse ☐ Son ☐ Daughter | Sex ☐ Male ☐ 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. (include prefix) | 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.)
- Name of patient
- Service provided
- Date of service
- Amount charged for each service
- Diagnosis code
- Procedure code
- 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 | Printed name | Date (MM/DD/YYYY) |
|---|---|---|
| X | | |

Reset Form Save and Print

## 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 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.

## Medical Claim Form instructions:

Please send claims to:

Anthem Blue Cross and Blue Shield
P.O. Box 105187
Atlanta, GA 30348-5187

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

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