Medical Claim Form

Read instructions on reverse side.

Mail to:
Anthem Blue Cross and Blue Shield
P.O. Box 37180
Louisville, KY 40233-7180

[redacted]

Anthem

PART I CUSTOMER AND PATIENT INFORMATION *(please print or type)*

1. Customer's name _____
   Address _____
   City _____ State _____ ZIP _____
   ☐ *New Address* Phone (_____) _____

2. Customer's sex ☐ male ☐ female

3. Group name

4. Customer's certificate or ID number
   _____
   Blue Cross Plan code _____
   (numbers found on ID card)
   N
   If arrow appears on ID card, copy numbers exactly.

5. Is the patient eligible for Medicare? ☐ yes ☐ no
   If yes, please read filing instructions on reverse side.
   Medicare Health Insurance Claim No. _____

6. **I authorize release to Anthem of any information pertaining to this claim.**
   _____ **Date** _____
   Patient's signature (parent or guardian, if minor)

7. Patient's name (first, middle, last)

8. Patient's relation to customer
   self (male) 1 ☐ | self (female) 2 ☐ | husband 3 ☐
   wife 4 ☐ | son 5 ☐ | daughter 6 ☐
   other male dependent 7 ☐ | other female dependent 8 ☐

9. Patient's birthdate _____ Age _____
   Customer's birthdate _____
   Spouse's birthdate _____

10. Is patient a full-time student 19 years of age or older?
    ☐ yes ☐ no
    If yes, name of school:

11. If the **patient** is other than the customer, is the patient covered by any other group medical policy (including Blue Cross and Blue Shield)? ☐ yes ☐ no If yes:
    Other policyholder's name _____
    Patient's employer _____
    Other insurer _____
    Other insurer's address _____
    Patient's certificate number _____
    Effective date of patient's contract _____

12. Was condition related to:
    A. Employment ☐ yes ☐ no B. Accident ☐ yes ☐ no
    Date _____

13. Describe the illness, injury or symptom _____
    Date symptom first appeared _____

PART II PHYSICIAN OR PROVIDER INFORMATION *(to be completed by physician or provider only)*

14. Date symptom first appeared	15. Date patient first consulted you for this condition	16. Has patient ever had similar symptoms? ☐ yes ☐ no	17. Referring physician
18. Name and address of facility where service was rendered (other than home or office)		19. For services related to hospitalization Admission date:	Discharge date:
20. Is patient totally disabled? ☐ yes ☐ no	Dates of total disability: From To	21. Was outside lab work performed? ☐ yes ☐ no Charge:	22. Was service related to routine physical? ☐ yes ☐ no

23. Diagnosis or nature of illness, injury or symptom. Relate diagnosis to procedure in column E by reference to numbers 1, 2, 3, etc. ▼
1.
2.
3.

24. A Date of service	B Place of service (see back)	C Type of service	D. **Description**: Explain unusual services or circumstances related to procedures, medical services, or supplies furnished for each date given. Procedure code. Circle one: CPT IV or BSA	E Diagnosis code	F Charges	G Days or Units	**H (Anthem use only)**

Internal use only | 25. Total charges | **To receive payment, you must indicate your Anthem identification number ◄ in Block 27.**

▼ Use ADVANCE Plan stamp here ▼

26. Patient account number

27. **Anthem identification number**

I certify that these services were performed by me or in my presence under my supervision.

28. Physician/provider name _____
Address _____
City _____ State _____ ZIP _____
► **Signature** _____

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INFORMATION FOR THE CUSTOMER/PATIENT:

1. Use this form for all your medical/surgical claims. Note: use a separate form for each patient and each physician or other provider.

2. ***Complete all items in Part I*** of the form for both the patient and the customer. (The *customer* refers to a member of an enrolled group or a direct-pay policyholder.)

3. Sign the form in the area provided (block 6).

4. *Any* items of information not completed in Part I will cause a delay in processing your claim.

5. After you have completed Part I, give the form to your physician.

For Medicare patients: If you are participating in Anthem's Medi-fill Automated Entry program, DO NOT FILE A CLAIM. Your claims information will be transferred to Anthem automatically by the Medical carrier. If you are not participating in Medi-fill Automated Entry, be sure to attach your Explanation of Medicare Benefits form (EOMB) to this claim. For information on how you can sign up for the automated entry program, write to the address on the front of this form.

INFORMATION FOR THE PHYSICIAN/PROVIDER:

1. Use a separate claim form for each patient and each physician/provider rendering services. If you are a member of a group practice, the services of all physicians in your group can be reported on one claim form if the first 11 digits of the Anthem identification numbers are the same.

2. Review Part I to make sure the customer has provided all information. Missing information will cause a delay in processing and payment of the claim.

3. Complete Part II, including all information pertinent to the patient's treatment.

4. Be sure your Anthem identification number appears in Block 27.

5. ADVANCE Plan providers should use the rubber stamp which has been provided to easily identify the claim as one from an ADVANCE Plan provider.

6. Mail the completed, signed form to the address on the front.

PLACE-OF-SERVICE CODE (Block 24-B)

1 (IH)	independent hospital
2 (OH)	outpatient hospital
3 (O)	physician's office
4 (H)	patient's home
5	day care facility (psy)
6	night care facility (psy)
7 (NH)	nursing home
8 (SNF)	skilled nursing facility
9	ambulance
0 (OL)	other locations
A (IL)	independent laboratory
B	other medical/surgical facility
D	residential substance abuse treatment center

INSURANCE FRAUD WARNING

Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.