Anthem

ONE PATIENT AND ONE PROVIDER PER CLAIM FORM
SEE REVERSE SIDE FOR CLAIM FILING INSTRUCTIONS

Subscriber Submitted Claim

1. IDENTIFCATION NUMBER	2. GROUP NUMBER	3. PATIENT NAME (Last, First, Initial)	4. PATIENT BIRTHDATE MO.	DAY	YR.

5. PATIENT SEX	6. PATIENT RELATIONSHIP TO SUBSCRIBER	7. SUBSCRIBER NAME (Last, First, Initial)
☐ MALE ☐ FEMALE	☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER	

8. SUBSCRIBER ADDRESS (Street, City, State, Zip Code)

COORDINATION OF BENEFITS INFORMATION - ANSWER "YES" OR "NO" TO ALL QUESTIONS

9. IF NO, GO TO QUESTION 10. WERE THESE SERVICES REQUIRED AS A RESULT OF A JOB-RELATED ILLNESS OR ACCIDENT? ☐ YES ☐ NO	9a. NAME AND ADDRESS OF EMPLOYER	9b. NAME AND ADDRESS OF COMPENSATION CARRIER	9c. DATE OF ACCIDENT

10. IF NO, GO TO QUESTION 11. WERE SERVICES REQUIRED FOR A CONDITION RESULTING FROM AN ACCIDENT OR INJURY CAUSED BY ANOTHER PARTY? ☐ YES ☐ NO	10b. DATE OF ACCIDENT OR INJURY

11. IF NO, GO TO QUESTION 12. IS PATIENT COVERED BY ANY OTHER GROUP HEALTH BENEFIT PLAN? ☐ YES ☐ NO	11a. NAME OF POLICY HOLDER	11b. NAME AND ADDRESS OF INSURANCE COMPANY	11c. POLICY HOLDER

12. IF NO, GO TO QUESTION 13. WERE SERVICES REQUIRED DUE TO AN AUTOMOBILE ACCIDENT? ☐ YES ☐ NO	12a. NAME AND ADDRESS OF AUTOMOBILE INSURANCE COMPANY	12b. DATE OF ACCIDENT

13. IF NO, GO TO QUESTION 14. IS PATIENT ELIGIBLE FOR PART A AND/OR PART B MEDICARE?			13b. MEDICARE NUMBER
	PART A	☐ YES ☐ NO	
	PART B	☐ YES ☐ NO	

14. ILLNESS OR SYMPTOMS - FOR REIMBURSEMENT

15. NAME OF PROVIDER OR HOSPITAL FACILITY OF SERVICE	16. IF PLACE OF SERVICE WAS OUTPATIENT HOSPITAL, PROVIDE NAME OF HOSPITAL FACILITY
17. IF WE HAVE QUESTIONS, WHO MAY WE CONTACT? NAME PHONE NUMBER	

PLEASE COMPLETE THE FOLLOWING AS A SUMMARY OF THE ITEMIZED BILLS YOU HAVE ATTACHED TO THIS CLAIM FORM

18. DATE OF SERVICE	19. PLACE OF SERVICE	20. CHARGE FOR SERVICE	21. BRIEFLY DESCRIBE THE SERVICES YOU RECEIVED

22. TOTAL CHARGES FOR WHICH YOU ARE REQUESTING CONDSIDERATION OF PAYMENT		PLACE OF SERVICE	IP - INPATIENT HOSPITAL	
		O - OFFICE	OP - OUTPATIENT HOSPITAL	P - PHARMACY
		H - HOME	NH - NURSING HOME	L - LAB

23. I CERTIFY TO THE ACCURACY AND COMPLETENESS OF ALL INFORMATION REPORTED BY ME ON THIS FORM AND AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM.

see attached	
SIGNATURE	DATE

FULL SIGNATURE AND DATE
REQUIRED ON EACH FORM
INCOMPLETE FORMS MAY DELAY PROCESSING. PLEASE ENSURE ALL FIELDS ARE ANSWERED

SUBSCRIBER CLAIM FILING INFORMATION (HOW TO FILE)

THIS FORM SHOULD BE USED FOR NON-PARTICIPATING PROVIDERS OR FOR FILING PRESCRIPTION DRUG CLAIMS.

Be sure to ask your provider of care if he/she bills a statement to Anthem Blue Cross and Blue Shield. Please submit statements only if the provider does not bill us directly. To receive benefits for RX, or for services by a provider who does not bill us directly, complete the claim form, attach itemized bills, and mail the white copy to the local Blue Cross and Blue Shield Plan in the state where the services are rendered.

Keep a duplicate copy of your itemized bills as they will not be returned to you. **This claim may be returned to you if all required information is not present.**

CLAIM FILING INSTRUCTIONS

(Corresponds to numbered items on claim form)

A separate claim form for each family member and each provider of care must be submitted.

ITEM NO.

1–8 Please complete all blocks. All fields required.
14 Statement of why these services were required.
15 Indicate the name of the physician, pharmacy, hospital or other institutional facility who has billed for services provided to the patient. **Only one provider per form** (however, multiple pharmacy bills may be attached to one claim form.)
16 If laboratory or radiology services are being billed by a professional provider, and the place of service was inpatient or outpatient hospital, indicate the name of the hospital.
18 Name and telephone number; whoever can help us if additional information is required.
19 Use a separate line for each date of service and receipt.
20 Write the appropriate code to indicate the place of service by using the legend below this section.
21 Indicate the total charge for each service.
22 Briefly indicate the type of service. i.e. lab, x-ray, surgery, therapy, cast, stitches, etc.
23 This amount represents the total of all charges to be considered for benefit.
24 Your signature attests to the accuracy and completeness of all information on the claim and the attachments and authorizes the release of your medical records by the provider to our office if necessary.

REQUIRED INFORMATION

Itemized Bills: Summarizing the services may help us better understand the attachments if they are not clear. The **attached** itemized bills must include the provider name, patient's name, date of service, detailed description of service, and amount charged for that service. These must be valid documents from the provider.

Psychotherapy: Length and type of session (group or individual). Name and professional status of the individual conducting the session.

Prescription Drugs: Patient's name, pharmacy name and address, purchase date, **drug name,** prescription number and charge. The bill or receipt must be issued by the pharmacy.

HELPFUL HINTS

- If you have questions or need assistance, contact Anthem Blue Cross and Blue Shield Customer Service.
- To reduce the possibility of small billings getting lost or separated, it would be helpful if you attach these to an 8 1/2 x 11 piece of paper.
- We encourage you to file claims within 90 days of the service date. Please refer to your Benefit Certificate for specific timely filing limitations.
- File only if the provider has not.

Important: If the services for this claim were provided by a participating physician or hospital, the benefit payment will go to the provider.

A complete description of your benefits, as well as limitations and exclusions applicable thereto, is available in the Benefit Certificate. Final interpretation of any and all provisions of the program is governed by the Benefit Certificate.