

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? <input type="checkbox"/> Yes <input type="checkbox"/> No	Relation to subscriber <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Son <input type="checkbox"/> Daughter		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of birth (MMDDYYYY)
Name of other health insurance company	Group no.	Employer name		Policy no.

**Section 2: Subscriber information (on Anthem Blue Cross ID card)**

Identification no. (include prefix)		Group no.		
Last name		First name		M.I.
Street address	Apt. no.	City	State	ZIP code
Home phone no.	Work phone no.		Date of birth (MMDDYYYY)	

**Section 3: Medical information**

**Healthcare services:** Use this section to report any COVERED health service that has not already been reported to this Anthem Blue Cross 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? \_\_\_\_\_ (MMDDYYYY)

Date of service (MMDDYYYY)	Diagnosis code	Procedure code	Tax ID	Amount
<b>Total</b>				<b>\$</b>

**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 <b>X</b>	Printed name	Date (MMDDYYYY)
-----------------------	--------------	-----------------

## How to use this form

Dear Member:

Usually, all providers of healthcare 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 healthcare 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 card.

### Section 3: Medical information

**Healthcare services:** Use this section to report any COVERED health service that has not already been reported to this Anthem Blue Cross 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  
P.O. Box 60007  
Los Angeles, CA 90060-0007

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

**For your protection California law requires the following to appear on this form.** Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.