DETACH HERE

GENERAL INSTRUCTIONS

NOTE: If the Provider of Service is an Anthem Blue Cross and Blue Shield Participating, Anthem Blue Cross and Blue Shield Preferred, or BlueCare Provider, it is not necessary to complete the claim form below, as they will submit directly to Anthem Blue Cross and Blue Shield.

IN ORDER TO AVOID DELAY, PLEASE FOLLOW THE INSTRUCTIONS LISTED BELOW.

1. A SEPARATE ENVELOPE MUST BE COMPLETED FOR EACH PATIENT.
2. If another health insurance carrier, including Medicare, has partially paid or denied this claim, include an EXPLANATION OF BENEFITS showing payment or denial from that carrier.
3. Itemized bills for service or supplies must include all of the following information:

- PATIENT'S FULL NAME
- PROVIDER'S NAME & ADDRESS
- DIAGNOSIS
- DATE & DESCRIPTION OF EACH SERVICE RENDERED OR SUPPLY PURCHASED
- CHARGE FOR EACH SERVICE OR SUPPLY
- PROCEDURE CODE

IF YOUR COVERAGE INCLUDES ANY OF THE SERVICES LISTED BELOW PLEASE READ THE FOLLOWING:

PRESCRIPTION DRUGS Include original drug receipt which indicates the name and address of pharmacy, drug name & number, strength, quantity, charge and number of days of usage.

DURABLE MEDICAL EQUIPMENT (PURCHASE OR RENTAL) Include a statement from physician indicating medical necessity and length of time for usage.

NURSING SERVICES Include an itemized bill and a progress report from the nurse which indicates nurse's registration number, state where registered, and the place of service. A statement from the physician indicating medical necessity must also be included.

AMBULANCE Include a bill indicating the point of origin, reason for transport, name of hospital where patient was treated, and date of admission.

PROSTHETIC APPLIANCE Include physician's statement indicating medical necessity and date condition was diagnosed.

OCCUPATIONAL THERAPY Include a completed certification form which is available at the therapist's office.

PHYSICAL THERAPY Include a bill which indicates the number of treatments, length of time per visit, and a description of the method of treatment.

PLEASE PRINT CLEARLY

PATIENT'S NAME (LAST, FIRST, MIDDLE)

PATIENT'S DATE OF BIRTH | SEX ☐ M ☐ F | PATIENT'S RELATIONSHIP TO MEMBER ☐ SELF ☐ SPOUSE ☐ CHILD

PATIENT'S ADDRESS (STREET, CITY, STATE, ZIP CODE)

MEMBER'S NAME (LAST, FIRST, MIDDLE)

MEMBER'S CURRENT ADDRESS (STREET, CITY, STATE, ZIP CODE)

☐ CHECK BOX IF A PERMANENT ADDRESS CHANGE

ANTHEM BLUE CROSS AND BLUE SHIELD IDENTIFICATION NO. - PLEASE INCLUDE PREFIX

List both if different

BLUE CROSS

BLUE SHIELD

NAME OF EMPLOYER

GROUP NUMBER

OTHER HEALTH INSURANCE COVERAGE? ☐ YES ☐ NO

NAME OF POLICYHOLDER

NAME OF INSURANCE CARRIER

EFFECTIVE DATE OF POLICY

IS ILLNESS/INJURY RELATED TO: PATIENT'S EMPLOYMENT? ☐ YES ☐ NO ACCIDENT? ☐ YES ☐ NO IF "YES" ☐ MOTOR VEHICLE ☐ OTHER

I authorize the release of any medical information to process this claim, and certify that the above information is complete and correct. I am claiming benefits only for charges incurred for the patient indicated above.

MEMBER'S SIGNATURE DATE

0200 (8/00)

FOLD

FOLD

FOLD

FOLD

FOLD

FOLD

DETACH HERE

Mail completed form to:

ANTHEM BLUE CROSS AND BLUE SHIELD
PO BOX 533
NORTH HAVEN, CT 06473-0533