Medical Claim Form

Anthem BlueCross BlueShield

Read instructions on reverse side.

Mail to:
Anthem Blue Cross and Blue Shield
PO Box 105187
Atlanta, GA 30348

PART 1: CUSTOMER AND PATIENT INFORMATION — Please print or type

1. Customer first name	M.I.	Last name	Street address ☐ New address	City	State	ZIP code	Phone no. ( )

2. Customer sex ☐ Male ☐ Female	3. Group name	4. Customer certificate or ID no. If arrow appears on ID card, copy numbers exactly. N	Anthem plan code (numbers found on ID card)

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.**
X _____ _____
Patient's signature (parent or guardian, if minor) **Date**

7. Patient first name	M.I.	Last name

8. Patient relation to customer
1 ☐ Self (male) 3 ☐ Husband 5 ☐ Son 7 ☐ Other male dependent
2 ☐ Self (female) 4 ☐ Wife 6 ☐ Daughter 8 ☐ Other female dependent

9. Patient birthdate	Age	Customer birthdate	Age	Spouse birthdate	Age	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 Anthem Blue Cross and Blue Shield)? ☐ Yes ☐ No If yes, complete the following.

Other policyholder name	Patient employer	Other insurer

Other insurer street address	City	State	ZIP code	Patient certificate no.	Effective date of patient contract

12. Was the condition related to: A. Employment ☐ Yes ☐ No B. Accident ☐ Yes ☐ No	Date	13. Describe the illness, injury or symptom	Date symptom first appeared

PART 2: PHYSICIAN OR PROVIDER INFORMATION — To be completed only by physician or provider

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 28.

⬇ Use ADVANCE Plan stamp here ⬇

26. Patient account number	27. Provider TIN	28. **Anthem identification number**

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

29. Physician/provider name			
Street address	City	State	ZIP code
Signature X		Date	

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 1** 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 1 will cause a delay in processing your claim.
5. After you have completed Part 1, 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 1 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 2, including all information pertinent to the patient's treatment.
4. Be sure your Anthem identification number appears in Block 28.
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.