Anthem

CLAIM FORM

See reverse side before filing your claim

1. Member Information

This number is necessary to process your claim

Member's Name		Certificate Number	Group Number
Street & Number or R.F.D.	City	State	Zip Code

2. Patient Information

Patient's Name	Sex	Date of Birth	Relationship to Subscriber
	M ☐ F ☐	Mo. Day Year	Self ☐ Spouse ☐ Son ☐ Daughter ☐

3. Diagnosis

What is the Illness or Injury Requiring Treatment?	If Accident, Give Date

4. Was this a work-related injury or illness?

Check one ➡ ☐ Yes ☐ No

Employer's Name	Address

5. Do you have other Group Health Insurance?

Check one ➡ ☐ Yes ☐ No

Name of Other Insurance Company	Type of Insurance	Policy I.D. Number	Contract Number
Street & Number or R.F.D.	City	State	Zip Code

6. Are you covered under the Medicare program?

Check one ➡ ☐ Yes ☐ No

Patient's Medicare Health Insurance Claim Number _____

7. Authorization and Signature(s)

I authorize any health care provider, medically related facility, health care plan, insurance company, and the Medical Information Bureau and their representatives to give Anthem Blue Cross and Blue Shield or their agents any and all information, including complete medical history records and mental health and substance abuse records, for consideration of this claim and all future claims. I certify that the above statements are complete and correct to the best of my knowledge and that I am claiming benefits only for charges incurred by the above named patient.

Signature of Patient (Parent if Minor) X _____ **Date:** _____

Signature of Member or Spouse X _____ **Date:** _____

Be sure section 7 is signed.

How To Receive Benefits

Step 1: Complete **all** areas of the Claim Form before returning the claim to us. If benefits are to be claimed for more than one family member, a separate claim form must be submitted for each member.

Step 2: Include itemized bills prepared by those who have rendered the services. Be sure the following information is provided:

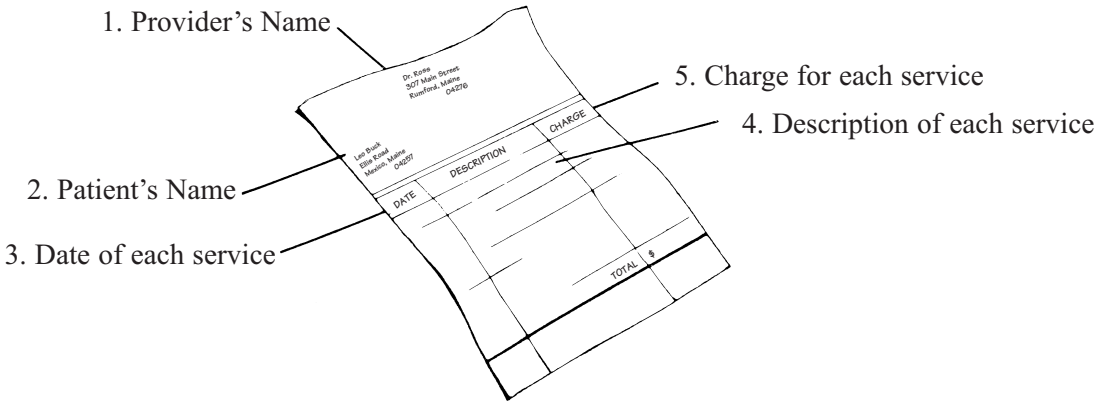
Medical Bills

1. Name of person or organization providing the service
2. Name of the patient
3. Date each service was provided
4. Description of each service
5. Charge for each service

Prescription Drug Bills

1. Name of drug
2. Prescription Number
3. Date of purchase
4. Amount of prescription

EXAMPLE:



Step 3: Sign and date claim form.

QUESTIONS?

Call customer service at the number on the back of your ID card, Monday through Friday from 8:00 a.m. - 5:00 p.m.. You may also use the secure on-line customer service form at www.anthem.com.

Step 4: Recheck **all** information and submit this form along with supporting material to:

Anthem Blue Cross and Blue Shield
P.O. Box 533
North Haven, CT 06473