

MEDICAL CLAIM FORM

PATIENT AND EMPLOYEE INFORMATION

Anthem Blue Cross ID Number	Group #	
1. Patient's Name	2. Patient's Date of Birth 	3. Employee's Name
4. Patient Address (Street, City, State, Zip Code)	5. Patients Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	6. Employee's Address (Street, City, State, Zip Code) <input type="checkbox"/> CHECK HERE IF NEW ADDRESS
	7. Patients Relationship to Employee <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	
8. OTHER HEALTH INSURANCE COVERAGE: Is patient covered by any other plan? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide name and address of carrier: _____ Identification Number _____ Name of Employer _____ Types of Coverage by Carrier: <input type="checkbox"/> Medical <input type="checkbox"/> Drug <input type="checkbox"/> Vision <input type="checkbox"/> Dental Effective Date of Coverage _____ Termination Date of Coverage _____		
9. Was condition related to accident? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please give details: When did the accident occur? (MM/DD/YY) _____		
10. Was condition related to Patient's Employment? <input type="checkbox"/> Yes <input type="checkbox"/> No When did the injury occur? (MM/DD/YY) _____		
11. I authorize the undersigned physician to release any information acquired in the course of my examination or treatment. _____ Signed (Employee or Patient) Date	12. I authorize payment of medical benefits to undersigned physician or supplier for service(s) described below. _____ Signed (Employee or Patient) Date	

REFER TO THE BACK OF YOUR I.D. CARD FOR PROPER MAILING ADDRESS



JOHN SAMPLE
HEALTHCARE ID:
123-45678D

SAMPLE

Group #: 123456M001
Anthem Blue Cross ID #: ABC123-45678D
Plan Code: 040
Rx Bin: 12345
Rx Group: ABCD
Rx PCN: EF
Plan Option: PPO

Always include trailing D and three digit alpha pre-fix from Anthem Blue Cross ID #.

Please verify the patient's identification

Prudent Buyer Plan ©



Attach itemized bill. Each itemized bill must include:

- Name and address of provider
- Provider Tax ID
- Name of patient
- Service provided
- Date of service
- Amount charged for each service
- Diagnosis Code
- Procedure Code

TO SUBMIT MANUAL CLAIMS

FOR MEDICAL CLAIMS IN CALIFORNIA

Anthem Blue Cross of California
PO Box 60007
Los Angeles, CA 90060-0007

FOR CLAIMS OUTSIDE OF CALIFORNIA

Anthem Blue Cross/Blue Shield of the state
the medical services were performed.

If you have questions, call
800-810-BLUE (2583)