# Member Medical Claim Form

See reverse side before filing your claim.

## Section 1: Member information

| Member last name | First name | M.I. |
|---|---|---|
| Certificate no./Identification no. – This number is necessary to process your claim | Group no. | |
| Street address or R.F.D. | City | State / ZIP code |

## Section 2: Patient information

| Patient last name | First name | M.I. |
|---|---|---|
| Sex ☐ Male ☐ Female | Birthdate (MMDDYYYY) | Relationship to subscriber ☐ Self ☐ Spouse ☐ Son ☐ Daughter |

## Section 3: Diagnosis

| What is the illness or injury requiring treatment? | If accident, give date: → | Date of accident (MMDDYYYY) |
|---|---|---|

## Section 4: Work-related

Was this a work-related injury or illness? ☐ Yes ☐ No If yes, complete the following:

| Employer name | | |
|---|---|---|
| Street address or R.F.D. | City | State / ZIP code |

## Section 5: Group health insurance

Do you have other Group health insurance? ☐ Yes ☐ No If yes, complete the following:

| Other insurance company name | Type of insurance | Policy ID no. | Contract no. |
|---|---|---|---|
| Street address or R.F.D. | City | State | ZIP code |

## Section 6: Medicare

Are you covered under the Medicare program? ☐ Yes ☐ No If yes, give patient's Medicare health insurance claim no.: _____

## Section 7: Authorization and signature(s) – Required.

I understand that any health care provider, medically related facility, health care plan, insurance company, or other organization and their representatives having personal health information pertaining to me is permitted to give Anthem Blue Cross and Blue Shield or their agents any and all information, including complete medical history records and (if and pursuant to a separate authorization signed by me as required by federal law) mental health and substance abuse records, for consideration of this claim and as may be permissible thereafter in accordance with applicable law.

**Important Fraud Warning Statement:** Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

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.

| Patient signature (parent if minor) X | Date (MMDDYYYY) |
|---|---|
| Member or spouse signature X | Date (MMDDYYYY) |



43923CTMENABS Rev. 2/19

Reset Form Save and Print

## 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:

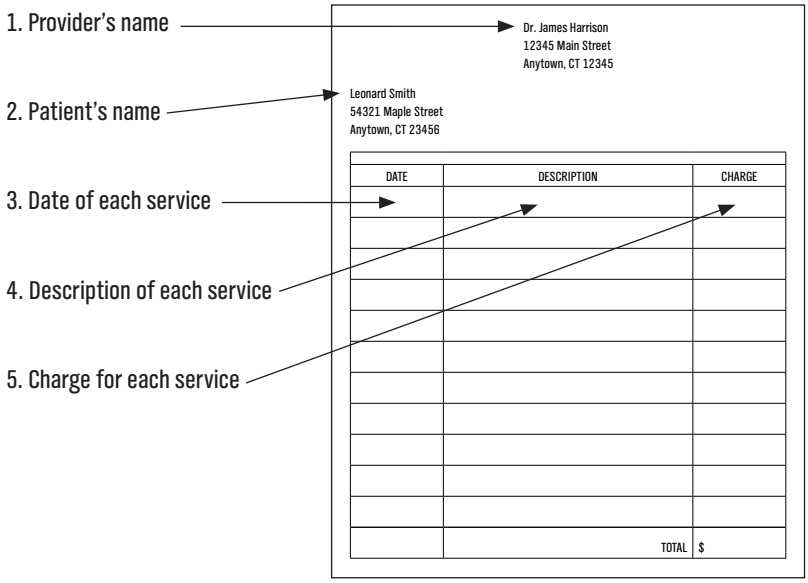
**Medical bills**

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 online customer service form at 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