

# Member Medical Claim Form



See reverse side before filing your claim.

## Section 1: Member information

Member last name	First name	M.I.	
Member ID no. – <b>This number is necessary to process your claim</b>	Group no.		
Street address	City	State	ZIP code

## Section 2: Patient information

Patient last name	First name	M.I.	
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Birthdate (MMDDYYYY)	Relationship to member <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Son <input type="checkbox"/> Daughter	

## Section 3: Diagnosis

What is the illness or injury requiring treatment?	If accident, give date: →	Date of accident (MMDDYYYY)
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## Section 4: Work-related

Was this a work-related injury or illness? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, complete the following:			
Employer name			
Street address	City	State	ZIP code

## Section 5: Other coverage

Do you have other Group health insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, complete the following:			
Other insurance company name	Type of insurance	Member ID no.	Contract no.
Street address	City	State	ZIP code

## Section 6: Medicare

Are you covered under the Medicare program? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, give patient's Medicare health insurance claim no.: _____
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## 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 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, confinement in prison, or a denial of insurance benefits.

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) <b>X</b>	Date (MMDDYYYY)
Member or spouse signature <b>X</b>	Date (MMDDYYYY)

