Medical Claim Form

Read instructions on reverse side.

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

Anthem BlueCross BlueShield

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.	Anthem plan code (numbers found on ID card)
		N	

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) 2 ☐ Self (female) 3 ☐ Husband 4 ☐ Wife 5 ☐ Son 6 ☐ Daughter 7 ☐ Other male dependent 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
		Please see attached for superbill for procedure/diagnosis code/charges/dates					

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			
Justin Ray, MSN, PMHNP-BC			
Street address	City	State	ZIP code
200 Carmichael Way, Suite 604	Chesapeake, VA 23322		
Signature X		Date	