

Medical Claim Form



Read instructions on reverse side.

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

PART 1: CUSTOMER AND PATIENT INFORMATION – Please print or type

1. Customer first name		M.I. Last name		Street address <input type="checkbox"/> New address		City	State	ZIP code	Phone no. ()
2. Customer sex <input type="checkbox"/> Male <input type="checkbox"/> 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)		
5. Is the patient eligible for Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> 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 <input type="checkbox"/> Self (male) 3 <input type="checkbox"/> Husband 5 <input type="checkbox"/> Son 7 <input type="checkbox"/> Other male dependent 2 <input type="checkbox"/> Self (female) 4 <input type="checkbox"/> Wife 6 <input type="checkbox"/> Daughter 8 <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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)? <input type="checkbox"/> Yes <input type="checkbox"/> 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 <input type="checkbox"/> Yes <input type="checkbox"/> No B. Accident <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No		Dates of total disability From: _____ To: _____		21. Was outside lab work performed? <input type="checkbox"/> Yes <input type="checkbox"/> No Charge: _____		22. Was service related to routine physical? <input type="checkbox"/> Yes <input type="checkbox"/> 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.							
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 200 Carmichael Way, Suite 604		City Chesapeake, VA 23322
State		ZIP code
Signature X		Date

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