Claim Form

Anthem BlueCross BlueShield

INSTRUCTIONS: Please complete the entire form and return it to Anthem Blue Cross and Blue Shield at the address provided. See page 2 for complete instructions on how to file your claim.

SECTION 1: MEMBER INFORMATION

Last name	First name	M.I.	Member ID no. (REQUIRED)	Group no.

Street address	City	State	ZIP code

SECTION 2: PATIENT INFORMATION

Last name	First name	M.I.	Sex ☐ Male ☐ Female	Birthdate

Relationship to member: ☐ Self ☐ Spouse ☐ Son ☐ Daughter

SECTION 3: DIAGNOSIS

What is the illness or injury requiring treatment?	If accident, give date

SECTION 4: WORK-RELATED INJURY OR ILLNESS

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

Employer name	Street address	City	State	ZIP code

SECTION 5: OTHER COVERAGE

Do you have other group health insurance? ☐ Yes ☐ No If yes, complete the following information.

Insurance company name	Type of insurance	Member ID no.	Contract no.

Street address	City	State	ZIP code

SECTION 6: MEDICARE COVERAGE

Are you covered under the Medicare program? ☐ Yes ☐ No If yes, complete the following information.	Patient Medicare health insurance claim no.

SECTION 7: AUTHORIZATION AND SIGNATURES — REQUIRED

I authorize any health care provider, medically related facility, health care plan, insurance company, and the Medical Information Bureau and their representatives to give Anthem Blue Cross and Blue Shield or their agents any and all information, including complete medical history records and mental health and substance abuse records, for consideration of this claim and all future claims. 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 signature if minor) X	Date

Member or spouse signature X	Date

Reset Form Save and Print

HOW TO RECEIVE BENEFITS

Step 1: Complete **all** areas of the claim form before returning the claim to us. Submit a **separate** claim form for **each** family member.

Step 2: Attach itemized bills from the person or organization that provided the services. Be sure to include the following information:

Medical Bills

1. Name of person or organization that provided service
2. Name of the patient
3. Date each service was provided
4. Charge for each service
5. Description of each service

Prescription Drug Bills

1. Name of drug
2. Prescription number
3. Date of purchase
4. Amount of prescription

MEDICAL BILL SAMPLE

Anthony Johnson, M.D.
12345 South Maple St. (1)
Anytown, ME 54321

George Appleton
2124 N.E. Main St. (2)
Anytown, ME 54321

DATE	DESCRIPTION	CHARGE
(3)	(4)	(5)
	TOTAL	$

Step 3: Sign and date the claim form.

Step 4: Recheck **all** information and send this form along with itemized bills and/or supporting materials to:

Anthem Blue Cross and Blue Shield
P.O. Box 533
North Haven, CT 06473

Questions? Call customer service at the number on the back of your ID card, Monday through Friday from 8:00 a.m. to 5:00 p.m.
Or, use the secure online customer service form at anthem.com.