[redacted]

Claim Form
to Pay Insured/Subscriber

P.O. Box 660603 • Dallas, TX 75266-0603

Each item on this form needs to be completed.
Instructions for completion are listed on the reverse side.

1

Insured/Subscriber Name (Last, First, Middle Initial)

Mailing Address

City and State | ZIP Code

Insured Employed? | Date of Retirement: Month Day

2

Group Number | Insured/Subscriber Identi cation Number (from ID card)

Patient's Full Name (Last, First, Middle)

Patient's Sex | Patient's Date of Birth Month Day Year _____/_____/_____

Patient's Relationship to Insured

.. Self .. Spouse .. Child .. Other (explain) _____

Describe: Diagnosis, symptoms of illness or injury or explain preventive or routine care received.

4 _____

_____

_____

5 Was illness or injury work connected? .. Yes .. No

Name and address of employer _____

_____

6 If injury, was a motor vehicle involved? .. Yes .. No

7

Is patient covered under any other health bene ts plan (besides Medicaid, Medicare or CHAMPUS)? .. Yes .. No

Insurance Co. _____

Address _____ Effective date of coverage Month Day Year _____/_____/_____

Employer _____ Sex of Insured .. Male .. Female

Insured name _____ Date of birth of insured _____/_____/_____

Policy # _____ Relationship to patient _____

If the other coverage is primary, attach the other insurance company's Explanation of Bene ts.

8

Medicare — Is the patient:

			Month Day Year
a) Entitled to bene ts under Medicare insurance (Part A)?	.. Yes .. No	Effective	_____/_____/_____
b) Entitled to bene ts under Medicare insurance (Part B)?	.. Yes .. No	Effective	_____/_____/_____
c) Entitled to bene ts under Medicare due to a disability?	.. Yes .. No	Effective	_____/_____/_____

Patient's Medicare Identi cation Number. (From Medicare ID card) _____

9

I certify the above is complete and correct and that I am claiming bene ts only for charges incurred by the patient named above. Authorization is hereby given to any Hospital, Physician, Dentist, Provider, Insurance Carrier or other entity to give Blue Cross and Blue Shield of Illinois, upon request, any medical information. Any person who knowingly presents a false or fraudulent claim for payment of a loss or bene t or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to ci vil nes and criminal penalties.

Signature of Insured | Date | Daytime telephone number

10

Total amount for ALL covered services and supplies received. | $

Itemized Bill(s) for covered services and supplies must be attached. (See Instructions on reverse side.)

INSTRUCTIONS

Important: DO NOT le this form if your Provider of Service is submitting these charges to Blue Cross and Blue Shield of Illinois.