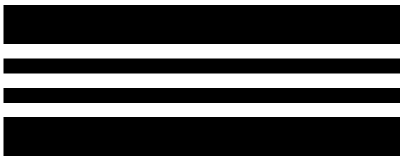
Please Do Not Staple On Bars

FOR OFFICE USE ONLY

CUSTOMER CLAIM FORM



P.O. Box 27401, Richmond, VA 23279

Please see the other side of this form for instructions and mailing information. A separate Customer Claim Form is required for each patient; attach only the bills for that family member. Please print or type all information.

INSURED AND PATIENT INFORMATION – ALL SECTIONS MUST BE COMPLETED

Insured's Name (as shown on ID card)
First M.I. Last

Identification Number (as shown on ID card)
(Letters if any) ( )

Patient's Name
First **M.I.** **Last**

Patient's Date of Birth
Month Day Year

Patient's Sex
❑ Male ❑ Female

Patient's Relationship to Insured ❑ Self ❑ Spouse ❑ Dependent Child

Insured's Street Address (❑ check if new address)

City State Zip Code

Daytime Phone Number
(in case additional information is needed)
( )

PATIENT'S CONDITION AND TREATMENT

Treatment was for
❑ Illness ❑ Injury

Condition was due to
❑ Work-Related Injury/Illness ❑ Auto Accident ❑ Other

If injury, give date
Month Day Year

What illness or injury was the patient treated for?

First date care was received for this illness or injury
Month Day Year

ATTACHMENTS

Please check the types of documents you have attached copies of:
❑ Itemized bill(s) for this patient
❑ Statement(s) showing how the same services were paid by the patient's primary health insurance company
❑ Statement(s) showing Medicare's payment for the same services

AUTHORIZATION

I certify that the information on this form is complete and correct to the best of my knowledge. I authorize the release of any medical information necessary to process this claim.

Signature of Insured ____________________ **Date** ____________

SEE INSTRUCTIONS ON OTHER SIDE BEFORE MAILING

INSTRUCTIONS FOR FILING A CLAIM

This form is designed to help you file a claim for health care services received by you or an enrolled family member. If a doctor, hospital, or other health care provider has already filed a claim directly with Anthem Blue Cross and Blue Shield on your behalf, please do not send a Customer Claim Form for the same services.

STEP 1. Complete the Insured and Patient Information section.

- Please print or type.
- All sections **must** be completed for processing. Make sure to write in your **Identification Number** as shown on your ID card including any letters in front of your number.
- Use a separate claim form for each family member and only attach bills for that family member.
- Please provide a daytime telephone number where you can be reached if more information is needed to process this claim.

STEP 2. Complete the Patient's Condition (diagnosis) and Treatment section.

STEP 3. Review the bills for health care services that you will be sending, and please keep a copy as bills cannot be returned. Bills must show an itemized charge for each service the patient received. Each bill must show:

- The patient's name.
- The name, address, and tax identification number of the health care provider.
- The date of each service, the charge for each service, and a description of each service.
- The Referral Number for specialist care if your program requires referrals from your Primary Care Physician.

STEP 4. Complete the Attachments section. If these same services were covered first by another health care plan (the patient's primary plan), make sure you have copies of the other plan's statements showing how each service was paid.

STEP 5. Sign the Authorization.

STEP 6. MAIL YOUR COMPLETED CLAIM TO:
Anthem Blue Cross and Blue Shield
P.O. Box 27401
Richmond, Virginia 23279

Anthem Blue Cross and Blue Shield is the trade name of Anthem Health Plans of Virginia, Inc.
An independent licensee of the Blue Cross and Blue Shield Association.
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FOR DRUG CLAIMS PLEASE NOTE

If you **do not** have a prescription drug card program and are filing for prescriptions covered under your medical plan, please use the section at the bottom of this page.
If you **do** have a plastic prescription drug card, there is a separate form you need to use to file claims for prescription charges. See your Benefits Administrator for further information.

PRESCRIPTION DRUG CLAIM INFORMATION

If you **are not** covered under a prescription drug card program, you can use this form to file prescription charges. **The front of this form must be completed.** Follow the same instructions above and attach itemized receipts for prescriptions.

If you **do not** have itemized receipts or a pharmacy print-out signed by the pharmacist, **have your pharmacist complete the sections below.** Complete a separate form for each family member.

Patient's Name ______________________________ Date ____________

Pharmacy Name ____

Pharmacy Address ____________________ City __________ State ______ Zip ______

PRESCRIPTION DRUG RECORD

Date of Purchase	Name and Strength of Drug	Prescription Number	Quantity	Prescribing Doctor	Charge	Pharmacist Signature

Total $ ________