

# Major Medical Claim Form

Mail to:  
Anthem Blue Cross and Blue Shield  
P.O. Box 37010  
Louisville, KY 40233-7010



1P

A separate claim form must be filed for each patient. Read instructions on reverse side.

## About The Employee

(Complete even if employee is not the patient)

Employee's name  
(From ID card)

Employee's identification number  
(From ID card)

Account number  
(From ID card)

Last

First

Employee's address

Street

City

State

Zip

Check if address is new

## About The Patient

Patient's first name  
(As shown on our records)

Patient's last name if different from employee's

Patient's birthday  
Month Day Year

Patient's sex  Male  Female

Patient is:  The employee  Your spouse  Your child

## About The Claim

Describe the illness, accident, or condition

### Accidents:

Were the services used as the result of an accident?  
 Yes  No

If "Yes" was the accident:

an auto accident  at work  
 at home  other \_\_\_\_\_

When did the accident happen? Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_ Time \_\_\_\_\_ : \_\_\_\_\_  AM  PM

**Other Coverage:** Does patient have other group health insurance?  Yes  No

If "Yes" and you have not previously answered the questions below, please complete. If you have already answered them, please ignore.

Policyholder: \_\_\_\_\_ Birthdate of Policyholder: \_\_\_\_\_

Name and address of the other insurance company: \_\_\_\_\_

Policy or certificate number: \_\_\_\_\_ Effective date of other insurance: \_\_\_\_\_

## Payments To Others

Is any payment on this claim to go to whoever provided services to you?  Yes  No If so, who?  
If you received services from a preferred provider, the provider will file your claim.

Name: \_\_\_\_\_ Address: \_\_\_\_\_

## Signatures

Both parts of this section must be signed or we will not process the claim.

A person who knowingly, and with intent to defraud an insurer, files a statement of claim containing any false, incomplete or misleading information commits a felony.

I have furnished the information on this form so that Anthem Insurance Companies, Inc. may consider this claim. By signing below, I certify that the information is correct and that the expenses were incurred by the patient named above.

If I have indicated that any payments on this claim are to be made to others, I authorize Anthem Insurance Companies, Inc. to make those payments directly. If any money is paid on this claim in error, or not authorized by the insurance contract, I agree to return it to Anthem Insurance Companies, Inc.

Employee's signature

Date

## Authorization to Release Information:

I authorize any insurance company, employer, organization, or provider of services to release any information related to this claim to Anthem Insurance Companies, Inc. or its authorized contractor before or after payment.

Patient's signature (even if employee) or parent or guardian of minor

Date

## Instructions

## Major Medical Claim Form

### When to Use This Form

Use this form to file a claim for benefits when:

- you (the group employee), your spouse, or your children have used the services of a doctor, hospital, ambulance, medical supply facility, pharmacy, or anyone else who provided services covered under your benefit program: **and**
- you have already paid for the services, or if whoever provided these services refuses to file a claim.

### When Not to Use This Form:

**Do not use this form for dental claims** or if any doctor or hospital has already submitted a claim for the services provided.

### Use a Separate Form For Each Patient

You must file a **separate** form for each patient claiming benefits. For example, if you and your child both see the same doctor on the same day, you must file two claim forms.

### How to File a Claim

#### Complete This Form.

Answer all questions on the other side of this form. Be sure to:

- enter your Anthem Blue Cross and Blue Shield identification and account numbers (from the front of your ID card);
- complete all answers about the employee whether you are the patient or not; and
- complete all information about the **patient**.

#### Attach Detailed Receipts

**We will not process your claim unless you attach receipts** for the services. **Receipts must be signed** by whoever provided the services or be on their letterhead and:

- show the patient's name;
- give the date the services were provided;
- describe the services, and diagnosis;
- indicate the charge for each service.

**Keep copies of your receipts.** We can't send back receipts you attach to this form, so we suggest you make copies of them for your records.

#### Claims for Nursing Care or Medical Equipment

**You must attach Nursing notes** from the nurse if the claim is for private duty nursing. The nurse who was on duty can provide these.

**You must attach a physician's prescription** describing the type of durable medical equipment needed and indicating how long it will be needed.

**You are encouraged to file claims at any time during the year, once your deductible has been met. However, you must file all Medical receipts by December 31st of the year FOLLOWING the year in which the service was provided.**

### Where to File your Claim

When you have completely filled out the other side of this form and attached detailed receipts, send your claim to *the address listed on the front of this form*.

### Filing Claims for Medicare Patients

If a patient is eligible for Medicare, read the following information carefully.

**File all bills.** File all doctor bills with Medicare in the state where the service was provided.

**The "Explanation of Medicare Benefits."** When Medicare has processed the claim, it will send an explanation of what it will pay. This is called an "Explanation of Medicare Benefits." Keep it. You may need it.

**Services in Indiana.** If the services were provided in Indiana, your claim will automatically be sent to us so we can process any Medicare Supplemental payments.

**Services outside Indiana.** If the services were provided outside Indiana, you must send us your "Explanation of Medicare Benefits" and itemized doctor's bills so we can process any Medicare Supplemental payments.

**Claims for unpaid charges.** When your Medicare Supplemental payment claim has been processed, you will receive a "Health Care Claims Summary" describing the action taken. If part of the claim remains unpaid at this point, you may make a claim for the unpaid charges under your Major Medical Plan. To do so:

- complete this form;
- attach your "Explanation of Medicare Benefits";
- attach the "Health Care Claims Summary" to your Medicare Supplemental payment claim; and
- **send these materials to us.**