# Major Medical Claim Form

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

# WELLNESS RIDER

A separate claim form must be filed for each patient. ***Read instructions on reverse side.*** 1P

## About The Employee

(Complete even if employee is not the patient)

Employee's name (From ID card) Last ______ First ______

Employee's identification number (From ID card) ______

Account number (From ID card) ______

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

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