

# 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.

Please print or type.

ГІСС	ise print or type.									
1	Insured/Subscriber Name (Last, First, Middle Initial)			Group Number	Insure	Insured/Subscriber Identification Number (from ID card)				
	Mailing Address			Patient's Full Name (Last, First, Middle)						
	City and State	ZIP Code	2	Patient's Sex	Patien	t's Date of Birth	Month	Day	Year	
	Insured Employed? Date of Retirement:			D				./	/	
	Month Day Year			Patient's Relationship to Insured						
	☐ Yes         ☐ No         ☐ Retired        /			Self Spouse Child Other (explain)						
				Month	Day	Year				
3	Type of treatment received:  Check only one type and attach itemized statements. Please use a separate claim form for each different type of treatment.		[	☐ Injury — Date of a		,	/			
	Please note: Preventive care includes immunizations, routine		[	☐ Illness — Date of first symptom:				/	/	
	well baby care, routine physical examinations, vision and		[	☐ Pregnancy — Date of conception:				/	/	
	hearing exams.		[	☐ Preventive — Date of service:				/	/	
	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									
			<b></b>							
6	If injury, was a motor vehicle involved?									
	Is patient covered under any other health benefits plan (besides Medicaid, Medicare or CHAMPUS)?									
7	Insurance Co						Month	Day	Year	
	Address Effective date of coverage						/	/		
	Employer Sex of Insured					 Temale	· - ·	···································		
	Insured name							,		
	Policy #									
If the other coverage is primary, attach the other insurance company's Explanation of Benefits.										
8	Medicare — Is the patient:						Month	Day	Year	
	a) Entitled to benefits under Medicare insurance (Part A)?			☐Yes ☐ No	Effecti	ve	/_	/_		
	b) Entitled to benefits under Medicare insurance (Part B)?			☐ Yes ☐ No	Effecti	ve	/_	/_		
	c) Entitled to benefits under Medicare due to a disability?			☐Yes ☐ No	Effecti	ve	/	/_		
	Patient's Medicare Identification Number. (From Medicare ID card)									
	I certify the above is complete and correct and that I am claiming benefits 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									
9	a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.									
	Signature of Insured Date Daytime					Daytime telep	elephone number			
						,	.,			
	Total amount for ALL covered convices and cumplies received					•	¢			
10	• •				\$					
	Itemized Bill(s) for covered services and supplies must be attached. (See Instructions on reverse side.)									
	1									

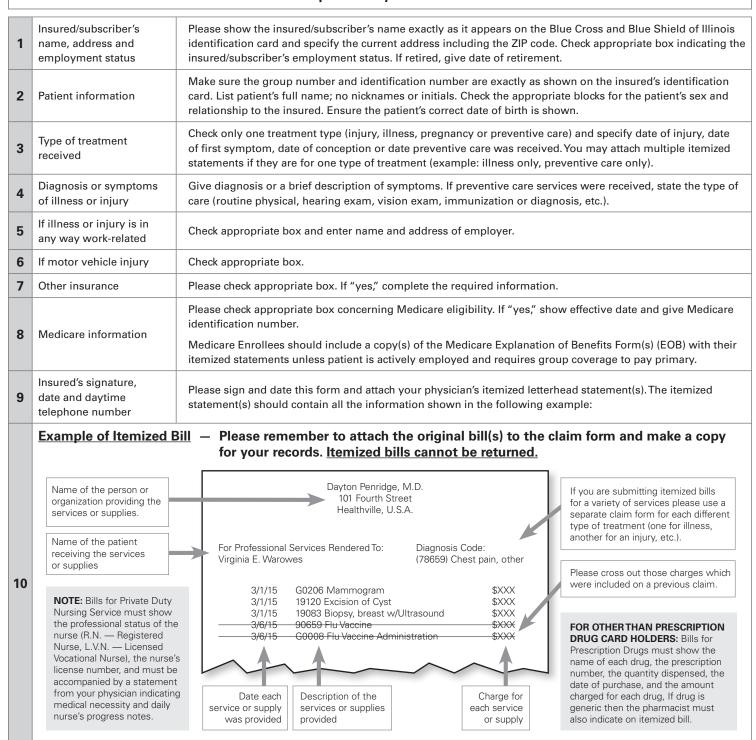


## Claim Form to Pay Insured/Subscriber

#### **INSTRUCTIONS**

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

Please complete every item on claim form.



This completed form, together with the itemized bills, should be submitted to: