Claim Form

Anthem

See reverse side before filing your claim.

Section 1: Member information

Member last name	First name	M.I.
Member identification no. — This is required to process your claim.	Group no.	
Street address	City	State / ZIP code

Section 2: Patient information

Patient last name	First name	M.I.
Date of birth (MMDDYYYY)	Relationship to subscriber ☐ Self ☐ Spouse ☐ Son ☐ Daughter	

Section 3: Diagnosis

What is the illness or injury?	If accident, give date: →	Date of accident (MMDDYYYY)

Section 4: Work-related

Was this a work-related injury or illness? ☐ Yes ☐ No If yes, complete the following:

Employer name			
Street address	City	State	ZIP code

Section 5: Other group health insurance

Is this patient covered by another group health plan? ☐ Yes ☐ No If yes, complete the following:

Policyholder name	Policyholder date of birth	Other insurance company name	Policy ID no.	Group no.

Section 6: Medicare

Is this patient covered by Medicare? ☐ Yes ☐ No If yes, give patient's Medicare health insurance claim no.: _____

☐ Part A — Effective date: (MMDDYYYY) ☐ Part B — Effective date: (MMDDYYYY)

☐ Part D — Effective date: Part D carrier/company name: _____

Section 7: Authorization and signature(s) — Required.

The patient must sign the claim form, authorizing the release of information to Anthem or its designee as described below. If the patient is a minor, the signature must be that of the patient's parent or legal guardian. I authorize any health care provider, payor of health claims, or government agency to furnish to Anthem or its designee all records pertaining to medical history, services rendered, and payments made regarding me or my dependents for review and evaluation of any claim or services. I authorize Anthem or its designee to disclose such information to another payor or self-insurer. If my coverage is under a group contract held by an employer, association, trust fund, union, or similar entity, this authorization also permits disclosure to them for purposes of utilization review or financial audit. This authorization shall become effective immediately, and shall remain in effect until the latest of six years after the termination of coverage, or the last determination or payment by Anthem on a claim or service under the coverage. This authorization shall be binding upon me, my dependents, my heirs, executors or administrators.

I certify that the above statements are complete and correct to the best of my knowledge and that I am claiming benefits only for charges incurred by the above named patient.

Important Fraud Warning Statement: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed **five thousand dollars** and the stated value of the claim for each such violation.

Patient signature or authorized representative X	Date (MMDDYYYY)
Member signature X	Date (MMDDYYYY)

114027NYMENABC Rev. 11/23

Reset Form Save and Print

How to request benefits

Use this form to file a claim when your doctor doesn't file the claim for you. You should send this completed claim form as soon as possible after you get care. Check your certificate of coverage for specific deadlines to submit your claim.

Step 1: Complete **all** areas of the *Claim Form* before returning the claim to us. If benefits are to be claimed for more than one family member, a separate claim form must be submitted for each member.

Step 2: Include the itemized bill you got from your doctor. It must include:

- Name, address, and tax ID number of provider (doctor, hospital, laboratory, ambulance service, etc.)
- Name of patient
- Service provided
- Date of service
- Place of service
- Amount charged for each service
- Diagnosis code
- Procedure code

Cancelled checks, cash register receipts and non-itemized "balance due" statements cannot be processed.

Step 3: Sign and date the claim form.

Step 4: Recheck **all** information and submit this form along with a copy of your itemized bill to:

Anthem Blue Cross
P.O. Box 1407
Church Street Station
New York, New York 10008–1407

Have questions or need help? Give us a call at the Member Services number on your ID card.

You may also use the secure online customer service form at anthembluecross.com.