Member Claim Form

Please use a separate claim form for each patient. Your cooperation in completing all items on the claim form and attaching all required documentation will help expedite quick and accurate processing.

PLEASE TYPE or PRINT • SEE REVERSE SIDE FOR COMPLETE INSTRUCTIONS

PATIENT INFORMATION			SUBSCRIBER INFORMATION (on Blue Cross Card)	
NAME Last First Middle Initial			MEMBER ID	GROUP NUMBER
BIRTHDATE	SEX ☐ M ☐ F	RELATION TO SUBSCRIBER ☐ Self ☐ Spouse ☐ Son ☐ Daughter	NAME Last First Middle Initial	
DOES THE PATIENT HAVE OTHER HEALTH INSURANCE COVERAGE? ☐ Yes ☐ No			ADDRESS	
NAME OF OTHER HEALTH INSURANCE COMPANY			CITY	STATE / ZIP CODE
POLICY NUMBER			HOME PHONE NO. ( )	WORK PHONE NO. ( )

MEDICAL INFORMATION

HEALTH CARE SERVICES: *Use this section to report any COVERED health service which has not already been reported to this Blue Cross Plan by the provider of service (the physician, clinical, ambulance company, private duty nurse, etc.) Attach itemized bill or photocopy. Please be sure that duplicate bills are not submitted.*

Was this medical expense the result of an accident? ☐ YES ☐ NO

Was this condition or injury job related? ☐ YES ☐ NO

Have you filed for Workers' Compensation? ☐ YES ☐ NO

On what day did this injury or accident occur? Month:____ Day:____ Year:____

Have you been treated for the same condition within the last 24 months? ☐ YES ☐ NO

If yes, indicate date you were last treated: Month:____ Day:____ Year:____

DATE OF SERVICE (Mo/Day/Yr)	PROVIDER OF SERVICE (Name of Doctor, Lab, Amb. Co., etc.)	SERVICE RENDERED (Office Visit, X-ray, etc.)	ILLNESS OR DIAGNOSIS	TOTAL

If the bill is from a Licensed Clinical Social Worker; Marriage, Family and Child Counselor; Audiologist; or Occupational, Physical, or Speech Therapist; what is the name of the physician who ordered the service?

Dr. _____

GRAND TOTAL

$

I certify that the information on this Member Claim Form is true and correct to the best of my knowledge. I authorize the release of any medical information necessary to process this claim.

X _____ _____

SIGNATURE OF SUBSCRIBER DATE

HOW TO USE THIS FORM

Dear Member:

Usually, all providers of health care will bill us for services to you and your enrolled dependents. This is the preferred procedure. You are not bothered with claim forms and we often need more details than are ordinarily provided on bills to patients.

Sometimes, a physician may not bill us or an ambulance company, for example, may send the bill directly to you. In either instance, we have no way of knowing about your claim. This Member Claim Form was developed to notify us of any covered health service for which we have not already been billed. Please read the following instructions about how to report Health Care Services.

We are happy to serve you.

PATIENT INFORMATION | **SUBSCRIBER INFORMATION (on Blue Cross Card)**

Use this section to identify the patient and subscriber. Some of this information may be found on your Blue Cross card.

MEDICAL INFORMATION

HEALTH CARE SERVICES: Use this section to report any COVERED health service which has not already been reported to this Blue Cross Plan by the provider of service (the physician, clinical, ambulance company, private duty nurse, etc.) Attach an itemized bill or photocopy. Please be sure that duplicate bills are not submitted.

DATE OF SERVICE (Mo/Day/Yr)	PROVIDER OF SERVICE (Name of Doctor, Lab, Amb. Co., etc.)	SERVICE RENDERED (Office Visit, X-ray, etc.)	ILLNESS OR DIAGNOSIS	TOTAL
7/9/91	John Wang, M.D.	Office Visit	Bronchitis	$35.00
7/9/91	Pat Fogarty, M.D.	X-ray	Strain	$57.00
				GRAND TOTAL
				$92.00

THE FOLLOWING INFORMATION MUST ALSO BE INCLUDED ON BILLS FOR THESE ITEMS:

REGISTERED AND LICENSED VOCATIONAL NURSES:

- Hours and dates of service
- Location of service (residence or name of hospital)
- Written documentation of physician's referral (must include the state license number, plan of treatment and estimated duration of treatments)

PROSTHETIC DEVICES, APPLIANCES OR DURABLE MEDICAL EQUIPMENT:

- Doctor's orders or prescription
- Purchase price

AMBULANCE:

- Pick-up and delivery points
- Number of miles

BILLS MUST BE ITEMIZED:

Cancelled checks, cash register receipts and non-itemized "balance due" statements cannot be processed. Each itemized bill must include:

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

MEMBER CLAIM FORM INSTRUCTIONS:

For services rendered **in California**, please send claims to P.O. Box 60007, Los Angeles, CA 90060

For **out-of-state** claims, please contact Customer Service for the claims office address. Out-of-state claims must be sent to the Blue Plan of the state in which services were rendered. For your convenience the Customer Service number is listed on your Member ID card.

NOTE: If your coverage includes Prescription Drug benefits, call (800) 700-2533 for customer assistance.