Subscriber Claim Form

Read instructions on reverse side.

Anthem

— IMPORTANT —

Please read and follow the instructions located on the front and back of this form. You are required to complete all unshaded areas of the form by printing clearly with a non-erasable ink pen. **This form will be returned to you if you do not provide the required information and attach an itemized bill from a hospital, doctor or supplier to the back of this form.**

1. PATIENT'S NAME (Last) (First) (M.I.)

2. PATIENT'S DATE OF BIRTH MONTH DAY YEAR

3. SUBSCRIBER'S CERTIFICATE NUMBER (INCLUDE ALPHA PREFIX)
PREFIX

4. PATIENT'S RELATIONSHIP TO SUBSCRIBER
SELF ☐ 1. SPOUSE ☐ 2. CHILD ☐ 3. OTHER ☐ 4.
SAME LAST NAME DEPENDENT

5. PATIENT'S SEX
MALE ☐ FEMALE ☐

6. SUBSCRIBER'S GROUP NUMBER
☐ CHECK IF NATIONAL ACCOUNT

7. SUBSCRIBER'S NAME (Last) (First) (M.I.)

8. WAS CONDITION RELATED TO:
A. PATIENT'S EMPLOYMENT? ☐ YES ☐ NO
B. ACCIDENT? ☐ YES ☐ NO

9. DATE ACCIDENT OR INJURY OCCURRED
MO. DAY YR.

10. SUBSCRIBER'S ADDRESS
STREET _____
CITY _____ STATE _____ ZIP _____
☐ NEW ADDRESS

11. IS THE PATIENT COVERED UNDER ANY OTHER HEALTH INSURANCE POLICY?
(If yes, indicate name of company and identification number)
☐ YES ☐ NO COMPANY NAME _____
IDENTIFICATION NUMBER _____

12. BILLING HOSPITAL, DOCTOR, SUPPLIER
NAME _____
STREET _____
CITY _____ STATE _____ ZIP _____

14. NAME(S) OF ILLNESSES OR INJURIES FOR WHICH THE PATIENT WAS TREATED

DIAGNOSIS CODE

1.

2.

3.

4.

BILLING PROVIDER I.D.

EIN/SSN I.D.

PAY CODE

13. REFERRING DOCTOR (DOCTOR WHO REFERRED PATIENT FOR TREATMENT)
NAME _____
STREET _____
CITY _____ STATE _____ ZIP _____

REFERRING PROVIDER I.D.

TYPE OF BILL

DO NOT WRITE IN SHADED AREA

15. DATE OF SERVICE (Mo./Day/Yr.) FROM TO	16.* PLACE OF SERVICE	REVENUE CODE	PROCEDURE CODE	17. DESCRIPTION OF SERVICE	DIAGNOSIS CODE	18. CHARGES	UNITS	ATTENDING PHYSICIAN I.D.

TOTAL SERVICES	TOTAL CHARGE	TOP 1 | 1

*** EXPLANATION OF BLOCK 16:** PLEASE INDICATE ONE OF THE FOLLOWING CODES TO IDENTIFY WHERE EACH SERVICE WAS PROVIDED.

DOCTOR'S OFFICE 1
PATIENT'S HOME 2
HOSPITAL/INPATIENT (BED PATIENT) 3
NURSING HOME (SKILLED NURSING FACILITY) 4
HOSPITAL/OUTPATIENT (EMERGENCY ROOM) 5
INDEPENDENT LAB 6
HOME HEALTH AGENCY 7
AMBULANCE 8
DURABLE MEDICAL EQUIP. SUPPLIER 9
PHARMACY (M & S SUPPLIES/DME) . . . . . .P

19. ATTENDING DOCTOR (DOCTOR WHO TREATED PATIENT)
NAME _____
STREET _____
CITY _____ STATE _____ ZIP _____

20. I AUTHORIZE THE RELEASE TO ANTHEM BLUE CROSS AND BLUE SHIELD OF ANY INFORMATION NECESSARY TO PROCESS THIS CLAIM.

SIGNATURE OF SUBSCRIBER

21. DATE FORM COMPLETED

THE PERSON SIGNING THIS FORM IS ADVISED THAT THE WILLFUL ENTRY OF FALSE OR FRAUDULENT INFORMATION RENDERS YOU LIABLE TO PROSECUTION.

3105 Rev. (8/04)

SUBMISSION INSTRUCTIONS

- Place itemized bill, receipt or Explanation of Benefits behind the completed Subscriber Claim Form. Send the completed Subscriber Claim Form and itemized bill, receipt or Explanation of Benefits to:

  Anthem Blue Cross and Blue Shield
  PO Box 533
  North Haven, CT 06473-0533

- This form is to be completed by the subscriber; accompanied by a copy of a hospital's UB-92 billing form (when hospital is outside of New Hampshire), or a doctor's or supplier's itemized bill or receipt, or an Explanation of Benefits from another health insurance plan or Medicare, and submitted to Anthem Blue Cross and Blue Shield for benefit consideration.
- Submit a completed Subscriber Claim Form for each patient with an itemized bill, receipt or Explanation of Benefits for that patient, as soon as a provider's (one provider per claim form) itemized bill, receipt or an Explanation of Benefits is received.
- **EACH ITEMIZED BILL OR RECEIPT MUST CONTAIN:**

  —Name and address of hospital, doctor or supplier
  —When the itemized bill or receipt lists the names of several doctors or suppliers, please circle the name and address of the individual who treated the patient.
  —Patient's name
  —Date of each service
  —Place of each service
  —Complete description of each service
  —Charge for each service
  —Additional information required for:
    —Ambulance bills—Destination transported and mileage accrued
    —Durable Medical Equipment bills—Purchase price whether rented or purchased. If rented, rental period, start and end date
    —Prescription drugs—Submit on Prescription Drug Claim Form
    —Private duty nurse—Degree of nurse and hours worked (day and night)

- **PLEASE RETAIN COPIES OF ITEMIZED BILLS, RECEIPTS OR EXPLANATION OF BENEFITS FOR YOUR RECORDS AS THEY WILL NOT BE RETURNED TO YOU.**
- **DATA BLOCKS REQUIRING SPECIAL ATTENTION**

  BLOCK 3 —You must include the 3-letter prefix, which is part of your Subscriber Certificate Number as found on your ID card.
  BLOCK 4 —Check OTHER when a dependent child's last name differs from the subscriber's last name
  BLOCK 6 —Check NATIONAL ACCOUNT when the subscriber's ID card indicates National Account.
  BLOCK 10 —Check NEW ADDRESS when subscriber's address is different from previous submission.
  BLOCK 14 —LIST THE ILLNESS OR INJURIES FOR WHICH THE PATIENT RECEIVED THE SERVICE(S) LISTED ON THE ITEMIZED BILL, RECEIPT OR EXPLANATION OF BENEFITS.
  BLOCK 17 —When applicable indicate the following information obtained from the itemized bill or the doctor's office:
    —Length of time for anesthesia, intensive care or psychotherapy sessions
    —Length, location and number of lacerations
    —Location and number of lesions

- **QUESTIONS OR PROBLEMS**

  If you have any questions regarding the completion of this form, or require additional Subscriber Claim Forms, please contact the Customer Service Center at the address listed below or call the Customer Service Number listed on the back of your Identification Card.

ADMINISTRATIVE OFFICE

Anthem Blue Cross and Blue Shield
PO Box 660
North Haven, CT 06473-0660