Personal Health Care
1-(800)-553-3164
(540) 342-7352

Anthem

CLAIM FORM

(Please Print or Type)

Anthem Blue Cross and Blue Shield is the trade name of Anthem Health Plans of Virginia, Inc.
An independent licensee of the Blue Cross and Blue Shield Association.

I. PATIENT AND POLICYHOLDER INFORMATION

Patient Name (Last) (First) (M.I.)	I.D. Number (Letters if any) ( )
(Street) (❑ check if new address) (City) (State) (Zip Code)	
Patient's Birthday Mo. Day Year	Patient's Sex ❑ Male ❑ Female
Patient's Relationship To Policyholder: ❑ Self ❑ Spouse ❑ Dependent Child	
Policyholder Name (as shown on ID card) (Last) (First) (M.I.)	Daytime Phone Number (in case additional information is needed) ( )

II. PATIENT'S CONDITION AND TREATMENT

Treatment was for ❑ Illness ❑ Injury ❑ Pregnancy	Condition was due to ❑ Work-Related Injury/Illness ❑ Auto Accident ❑ Other If work-related, is the patient self-employed and/or eligible for Worker's Compensation? ❑ Yes ❑ No	If injury, give date Mo. Day Year
What illness or injury was the patient treated for?	First date care was received for this illness or injury Mo. Day Year	

III. AUTHORIZATION

I certify that the information I have given is accurate to the best of my knowledge and that I, as the Insured, am claiming benefits only for the charges incurred by the patient identified above.

I authorize any health care provider of services or supplies, insurance company, or any other organization, institution, or person that has records or knowledge of me or my health, to furnish to the Medical Review, Claims, and Underwriting departments, or agents of Anthem Blue Cross and Blue Shield, information concerning services or supplies provided to me or to persons covered, for the purposes of review, investigation, or evaluation of an application or claim. A copy of this authorization is available to me or my authorized representative upon request. For claims purposes, this authorization is valid for the duration of coverage.

Policyholder Signature _____ Date _____

Please PRINT Policyholder's Name Here: _____

IV. INSTRUCTIONS

This claim form is designed to help you, the insured, file itemized health care related bills for you or an enrolled family member. If your doctor or hospital files directly with Anthem Blue Cross and Blue Shield, please do not file claims for the same services. Please review your health care bills at least once a month to assure timely filing of claims. (We request that you file claims within 90 days after the covered service is incurred.)

STEP 1. Complete the Patient and Policyholder Information section.

- Please print or type and complete all sections.
- Make sure to write in your **Identification Number** as shown on your ID card including any letters in front of your number.
- Use a separate claim form for each family member and only attach bills for that family member.

STEP 2. Complete the Patient's Condition (diagnosis) and Treatment section.

INSTRUCTIONS CONTINUED ON OTHER SIDE. SEE BEFORE MAILING

Form No. 900508 (12/02)

IV. INSTRUCTIONS

STEP 3. **Review the bills for health care services that you will be sending,** and please keep a copy as bills cannot be returned. When filing for these services please include:

- For Physician Services — Professional Service Report (PSR) or Health Insurance Claim Form (HICF).
- For Hospital Services — local Blue Cross, Hospital, or UB92 Form.

OR, an itemized bill showing charges for each service the patient received. Each bill must show:

- The patient's name.
- The name, address, and professional status of the health care provider.
- The date of each service, the charge for each service, CPT code (a description of each service) and diagnosis codes.

When filing for Private Duty Nurses or Home Care Equipment, include **BOTH** an itemized bill **AND** a letter of Medical Necessity from your doctor.

If these same services were covered first by another health care plan (the patient's primary plan), make sure you have copies of the other plan's statements showing how each service was paid. **Use the bottom of this form for prescription drugs.**

STEP 4. **Sign the Authorization.**

STEP 5. **MAIL YOUR COMPLETED CLAIM TO:** Anthem Blue Cross and Blue Shield, P.O. Box 27401, Richmond, VA 23279-7401

V. RECORD OF PRESCRIPTION DRUGS

A. If you use this form for prescription drugs, both sides must be completed.

Patient's Name: _____ Date _____

Pharmacy's Name: _____

Pharmacy Telephone Number: _____

1. A separate Record of Prescription Drugs must be kept for **EACH PERSON** enrolled.
2. This record should be used for:
   - Drugs and medicines which can be dispensed by prescription only according to Federal and State law.
   - Insulin and syringes prescribed for diabetic patients.
3. Other medications which do not require a prescription should not be recorded.

B. If you are attaching a signed pharmacy printout and/or the original receipt that provides the requested information below, it is not necessary to fill out this part of the form.

Date of Purchase	Name and Strength of Drug	Prescription No.	Quantity	Days Supply	Prescribing Doctor	Charge	Pharmacist Signature

TOTAL $ _____