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GENERAL INSTRUCTIONS

NOTE: If the Provider of Service is an Anthem Blue Cross and Blue Shield Participating, Anthem Blue Cross and Blue Shield Preferred, or BlueCare Provider, it is not necessary to complete the claim form below, as they will submit directly to Anthem Blue Cross and Blue Shield.

IN ORDER TO AVOID DELAY, PLEASE FOLLOW THE INSTRUCTIONS LISTED BELOW.

1. A SEPARATE ENVELOPE MUST BE COMPLETED FOR EACH PATIENT.
2. If another health insurance carrier, including Medicare, has partially paid or denied this claim, include an EXPLANATION OF BENEFITS showing payment or denial from that carrier.
3. Itemized bills for service or supplies must include all of the following information:
 - PATIENT'S FULL NAME
 - DATE & DESCRIPTION OF EACH SERVICE
 - PROCEDURE CODE
 - PROVIDER'S NAME & ADDRESS
 - RENDERED OR SUPPLY PURCHASED
 - CHARGE FOR EACH SERVICE OR SUPPLY
 - DIAGNOSIS

IF YOUR COVERAGE INCLUDES ANY OF THE SERVICES LISTED BELOW PLEASE READ THE FOLLOWING:

PRESCRIPTION DRUGS Include original drug receipt which indicates the name and address of pharmacy, drug name & number, strength, quantity, charge and number of days of usage.

DURABLE MEDICAL EQUIPMENT (PURCHASE OR RENTAL) Include a statement from physician indicating medical necessity and length of time for usage.

NURSING SERVICES Include an itemized bill and a progress report from the nurse which indicates nurse's registration number, state where registered, and the place of service. A statement from the physician indicating medical necessity must also be included.

AMBULANCE Include a bill indicating the point of origin, reason for transport, name of hospital where patient was treated, and date of admission.

PROSTHETIC APPLIANCE Include physician's statement indicating medical necessity and date condition was diagnosed.

OCCUPATIONAL THERAPY Include a completed certification form which is available at the therapist's office.

PHYSICAL THERAPY Include a bill which indicates the number of treatments, length of time per visit, and a description of the method of treatment.

PLEASE PRINT CLEARLY

PATIENT'S NAME (LAST, FIRST, MIDDLE)			ANTHEM BLUE CROSS AND BLUE SHIELD IDENTIFICATION NO. - PLEASE INCLUDE PREFIX				
PATIENT'S DATE OF BIRTH	SEX <input type="checkbox"/> M <input type="checkbox"/> F	PATIENT'S RELATIONSHIP TO MEMBER <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD	List both if different				
PATIENT'S ADDRESS (STREET, CITY, STATE, ZIP CODE)			BLUE CROSS				
			BLUE SHIELD				
MEMBER'S NAME (LAST, FIRST, MIDDLE)			NAME OF EMPLOYER				
MEMBER'S CURRENT ADDRESS (STREET, CITY, STATE, ZIP CODE)			GROUP NUMBER				
			OTHER HEALTH INSURANCE COVERAGE? <input type="checkbox"/> YES <input type="checkbox"/> NO				
			NAME OF POLICYHOLDER				
			NAME OF INSURANCE CARRIER				
<input type="checkbox"/> CHECK BOX IF A PERMANENT ADDRESS CHANGE			EFFECTIVE DATE OF POLICY				

IS ILLNESS/INJURY RELATED TO: PATIENT'S EMPLOYMENT? YES NO ACCIDENT? YES NO IF "YES" MOTOR VEHICLE OTHER

I authorize the release of any medical information to process this claim, and certify that the above information is complete and correct. I am claiming benefits only for charges incurred for the patient indicated above.

MEMBER'S SIGNATURE

DATE

0200 (8/00)

Mail completed form to:

ANTHEM BLUE CROSS AND BLUE SHIELD
PO BOX 533
NORTH HAVEN, CT 06473-0533