

P.O. Box 660044 Dallas, Texas 75266-0044

### Claim Form to Pay Insured/Subscriber

### **Please Print or Type**

# Each item on this form needs to be completed. Instructions for completion are listed on the reverse side.

		Т							
1	Insured/Subscriber Name (Last, First, Middle Initial)	2 Group Number		Insured/Subscriber Identification Number (from ID card)					
	Mailing Address	Patie	nt's Full Name (Last,	First, Middle)					
	City & State Zip Code	Patie	nt's Sex	Patient's Date	of Birth	Month	Day	Year	
			Male  Female			///////		/	
	Insured Employed? Date of Retirement Month Date Year	Patie	nt's Relationship to In	sured					
	Yes No Retired	1. 🗆	Self 2. ☐ Spouse	3. ☐ Child 4.☐	Other (explain	in)			
3	Type of treatment received:					Month	n Day	Year	
	Check only one type and attach itemized statements.  Please use a separate claim form for each different type		☐ Injury — Date of Accident:			//			
	of treatment.	<ul><li>☐ Illness — Date of First Symptom:</li><li>☐ Pregnancy — Date of Conception:</li></ul>				/			
	*Please note: Preventive care includes immunizations, routine well baby care, routine physical examinations,		•			://			
	routine well baby care, routine physical examinations, vision and hearing exams.						//		
4	Describe: Diagnosis, Symptoms of Illness or Injury or explain Preventive or Routine care received.								
5	Was Illness or Injury work connected? $\qed$ Yes $\qed$ N	10	Name and Add	lress of Emplo	yer				
6	If Injury, was motor vehicle involved? $\ \ \square$ Yes $\ \ \square$ N	lo							
7	Is patient covered under any other Health Benefits Plan (besides Medicaid, Medicare or CHAMPUS)? ☐ Yes ☐ No								
	Insuring Co.		-			Month	Day ,	Year	
	Address		Effective Date of	ll ( -		_/	_/		
	Employer		Sex  Male  Insured	ured)		_/	_/		
	Insured		Relationship to	Patient					
	If the other coverage is primary, attach the other insurance company's Explanation of Benefits								
8	Medicare — Is the Patient:		. , .			Month	Day	Voor	
U	a) Entitled to Benefits Under Medicare Hospital Insur	ance	(Part A)?	□ Ves □ No	Effective	Month	Day /	Year /	
	b) Entitled to Benefits Under Medicare Medical Insura		,	☐ Yes ☐ No			_/ _/	_/	
	c) Entitled to Benefits Under Medicare Medicar Insula		` ,	☐ Yes ☐ No			_/ /	_/	
	,		□ res □ no	Ellective		_/	_/		
Patient's Medicare Identification No. (From Medicare ID Card)									
9 I certify the above is complete and correct and that I am claiming benefits only for charges incurred by the p									
	above. Authorization is hereby given to any Hospital, Physician, Dentist, Provider, Insurance Carrier or other entity to g								
	Blue Cross and Blue Shield of Texas, upon request, any medical information which the Plans in their judgment deem necessary to the adjudication of this claim. Any person who knowingly presents a false or fraudulent claim for the payme of a loss is guilty of a crime and may be subject to fines and confinement in state prison.								
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	2 32 7 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2								
	Signature of Insured	 Date			Daytime Telephone Number				
	Signature of insured		Date		Dayunie	CIEPLIONE	MALLINE		

Itemized Bill(s) for Covered Services and Supplies must be attached

(See Instructions on Reverse Side)

### Instructions

## Important: Do Not file this form if your Provider of Service is submitting these charges to Blue Cross and Blue Shield of Texas.

### Please complete every item on claim form.

1 Insured's/Subscriber's Name, Address and Employment Status

Please show the insured's/subscriber's name exactly as it appears on the Blue Cross and Blue Shield of Texas identification card and specify the current address including the ZIP code. Check appropriate box indicating the insured's /subscriber's employment status. If retired, give date of retirement.

2 Patient Information

Make sure the group number and identification number are exactly as shown on the insured's identification card. List patient's full name; no nicknames or initials please. Check the appropriate blocks for the patient's sex and relationship to the insured. Ensure the patient's correct date of birth is shown.

Type of Treatment Received

Check only one treatment type (injury, illness, pregnancy or preventive care) and specify date of injury, date of first symptom, date of conception or date preventive care was received. You may attach multiple itemized statements if they are for one type of treatment (example: illness only, preventive care only).

Diagnosis or Symptoms of Illness or Injury

Give diagnosis or a brief description of symptoms. If preventive care services were received, state the type of care (routine physical, hearing exam, vision exam or immunization diagnosis, etc.).

If Illness or Injury is in any way work related

Check appropriate box and enter name and address of employer.

6 If Motor Vehicle Injury

Check appropriate box.

7 Other Insurance

Please check appropriate box. If "yes," complete the required information.

8 Medicare Information

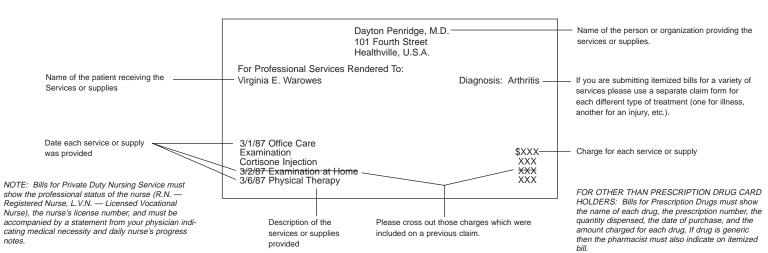
Please check appropriate box concerning Medicare eligibility. If "yes," show effective date and give Medicare identification number.

Medicare Enrollees should include a copy(s) of the Medicare Explanation of Benefits Form(s) (EOB) with their itemized statements unless patient is actively employed and requires group coverage to pay primary.

 Insured's Signature, Date and Daytime Telephone Number Please sign and date this form and attach your physician's itemized letterhead statement(s). The itemized statement)s) should contain all the information shown in the following example:

### Itemized Bills Cannot Be Returned

#### Example of Itemized Bill



This completed form, together with the itemized bills should be submitted to:

Blue Cross and Blue Shield of Texas P.O. Box 660044 Dallas, Texas 75266-0044

Additional copies of this form may be obtained from your Employer, our nearest Blue Cross and Blue Shield Area Office, or the above address.