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 ID Card)		
Name Last First M.I.			Social Security or ID No.		
Birthdate	Sex ☐ M ☐ F	Relation to Subscriber ☐ Self ☐ Spouse ☐ Son ☐ Daughter	Name Last First M.I.		
Does the patient have other health insurance coverage? ☐ Yes ☐ No			Address		
Name of other health insurance company			City	State	ZIP Code
Policy No.			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, Ambulance Co., etc.)	**Service Rendered** (Office Visit, X-ray, etc.)	**Illness or Diagnosis**	**Total**

If the bill is from a licensed clinical social worker, a marriage, family and child counselor, an audiologist, or an 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 and belief.

Signature of Subscriber	Date
X	

HOW TO USE THIS FORM

Dear Member:

Usually, all providers of health care coverage 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 ID Card)
Use this section to identify the patient and subscriber. Some of this information may be found on your Blue Cross ID 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 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, Ambulance Co., etc.)	Service Rendered (Office Visit, X-ray, etc.)	Illness or Diagnosis	Total
7/9/02	John Wong, M.D.	Office Visit	Bronchitis	$35.00
7/9/02	Pat Fogerty, 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

Send completed MEMBER CLAIM FORM and written inquires to:

P.O. Box 60007,
Los Angeles, CA 90060

Send address changes to:
P.O. Box 9051
Oxnard, CA 93031

For questions regarding claims and membership benefits, please call 1-800-333-0912.

NOTE: If your coverage includes Prescription Drug Benefits and you have questions, please call 1-800-700-2533.