Member Medical Claim Form

See reverse side before filing your claim.

Anthem®
And Its Affiliate HealthKeepers, Inc.

Section 1: Member information

Member last name	First name	M.I.
Member ID no. – This number is necessary to process your claim	Group no.	
Street address	City	State / ZIP code

Section 2: Patient information

Patient last name	First name	M.I.
Sex ☐ Male ☐ Female	Date of birth (MMDDYYYY)	Relationship to member ☐ Self ☐ Spouse ☐ Son ☐ Daughter

Section 3: Diagnosis

What is the illness or injury?	If accident, give date: →	Date of accident (MMDDYYYY)

Section 4: Work-related

Was this a work-related injury or illness? ☐ Yes ☐ No If yes, complete the following:

Employer name		
Street address	City	State / ZIP code

Section 5: Other coverage

Do you have other Group health insurance? ☐ Yes ☐ No If yes, complete the following:

Policyholder name	Policyholder date of birth	Other insurance company name	Policyholder member ID no.	Group no.

Section 6: Medicare

Are you covered under the Medicare program? ☐ Yes ☐ No If yes, give patient's Medicare health insurance claim no.: _____

☐ Part A – Effective date: (MMDDYYYY) ☐ Part B – Effective date: (MMDDYYYY)

☐ Part D – Effective date: Part D carrier/company name: _____

Section 7: Authorization and signature(s) – Required.

I understand that any health care provider, medically related facility, health care plan, insurance company, or other organization and their representatives having personal health information pertaining to me is permitted to give Anthem Blue Cross and Blue Shield or their agents any and all information, including complete medical history records and (if pursuant to a separate authorization signed by me as required by federal law) mental health and substance abuse records, for consideration of this claim and as may be permissible thereafter in accordance with applicable law.

I certify that the above statements are complete and correct to the best of my knowledge and that I am claiming benefits only for charges incurred by the above named patient.

Important Fraud Warning Statement: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines, confinement in prison, or a denial of insurance benefits.

Patient signature (parent if minor) X	Date (MMDDYYYY)
Member or spouse signature X	Date (MMDDYYYY)

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Reset Form Save and Print

How to request benefits

Use this form to file a claim when your doctor doesn't file the claim for you. You should send this completed claim form as soon as possible after you get care. Check your certificate of coverage for specific deadlines to submit your claim.

Step 1: Complete **all** areas of the claim form before returning the claim to us. If benefits are to be claimed for more than one family member, a separate claim form must be submitted for each member.

Step 2: Include the itemized bill you got from your doctor. It must include:

- Name, address, and tax ID or NPI number of provider (doctor, hospital, laboratory, ambulance service, etc.)
- Name of patient
- Service provided
- Date of service
- Place of service (doctor's office, lab, hospital, ambulance, etc.)
- Amount charged for each service
- Diagnosis code
- Procedure code

If any of this information is missing it might cause a delay when your claim is processed.

Cancelled checks, cash register receipts and non-itemized "balance due" statements cannot be processed.

Step 3: Sign and date claim form.

Step 4: Recheck all information and submit this form along with a copy of your itemized bill to:

Anthem Blue Cross and Blue Shield
P.O. Box 27401
Richmond, VA 23230

Have questions or need help?

Give us a call at the Member Services number on your ID card.
You may also use the secure online customer service form at anthem.com.