HEALTH INSURANCE CLAIM FORM

SUBSCRIBER INFORMATION (Person whose name is on contract.)

1) Subscriber's Last Name First Name Middle Initial

2) Daytime Telephone Number ( )

3) Identification Number (IID)

4) Group Number

5) Plan Number

6) Subscriber's Address, Number and Street City State Zip

7) Employer's Name (Group Name if applicable)

8) Check here if new address ☐

PATIENT INFORMATION (Use a separate form for each patient.)

9) Patient's Last Name First Name Middle Initial

10) Date of Birth

11) Sex ☐ Male ☐ Female

12) Patient is (check one): ☐ Subscriber (contract holder) ☐ Spouse (of contract holder) ☐ Child ☐ Other (specify) ______________

13) Patient Enrolled in (If yes, give Identification Number and Effective Date)

Medicare Part A (Hospital)? ☐ No ☐ Yes

Medicare Part B (Medical)? ☐ No ☐ Yes

Other Blue Cross & Blue Shield Membership? ☐ No ☐ Yes

Other Health Insurance Plan? ☐ No ☐ Yes

Identification Number: ________________________________

Effective Date: ____________________________________

14) Was Treatment for:

			Date of Accident
Accident at Work	☐ No	☐ Yes	_____/____/____
Other Accident	☐ No	☐ Yes	_____/____/____

Name of Policyholder: ____

Name of Other Insurance: ____

Address of Other Insurance: ____

Please attach a copy of the Explanation of Benefits from Other Insruance Carrier.

CLAIM INFORMATION

Dates of Service From Mo. Day Yr.	To (Discharge) Mo. Day Yr.	Description of Service	Provider Name	Description of Illness	Amount Charged

Total No. of Bills Attached: _______________ Total Charges $_______________

15) I certify the above information is correct and that charges were incurred by the above named patient.

____

(Signature) (Date)