COMPREHENSIVE CLAIM FORM FOR BENEFITS

Please submit your claim(s) with original bill(s) you received from the Provider or with the Provider's original signature on the attached bill(s).

1. NAME OF SUBSCRIBER (Employee or Retiree)	PATIENT'S NAME	
STREET	GROUP NUMBER 38000	SUBSCRIBER IDENTIFICATION (AS SHOWN ON YOUR IDENTIFICATION CARD)
CITY	SEX ☐ MALE ☐ FEMALE	PATIENT'S RELATIONSHIP TO SUBSCRIBER 1. ☐ SELF 2. ☐ SPOUSE 3. ☐ CHILD 4. ☐ OTHER (Explain)
STATE ZIP CODE	PATIENT'S DATE OF BIRTH MUST BE ACCURATE THIS IS PART OF IDENTIFICATION	______/______/______ Month Date Year

2. DESCRIBE THE ILLNESS OR INJURY REQUIRING TREATMENT ______________________________

____

3. WAS TREATMENT RESULT OF (ENTER EITHER 1,2, OR 3) ☐ INJURY (DATE OF ACCIDENT) OR ILLNESS (DATE OF FIRST SYMPTOM) OR PREGNANCY (DATE OF CONCEPTION) SHOW DATE: ______ /______ /______ Month Day Year

4. IF INJURY, WAS MOTOR VEHICLE INVOLVED? ☐ YES ☐ NO
WAS ILLNESS OR INJURY WORK CONNECTED? ☐ YES ☐ NO ______________ NAME AND ADDRESS OF EMPLOYER

5. IS PATIENT COVERED UNDER ANY OTHER HEALTH BENEFITS PLAN HELD BY REASON OF LAW OR EMPLOYMENT? ☐ YES ☐ NO
(IF "YES" COMPLETE THE REMAINDER OF THIS SECTION)

NAME OF INSURING CO ______________ ADDRESS ______________

NAME OF POLICY HOLDER ______________ BIRTH DATE ______ /______ /______ (MONTH DAY YEAR) SEX ☐ MALE ☐ FEMALE

EMPLOYER'S NAME______________ EFFECTIVE DATE OF COVERAGE ______/______/______ (MONTH DAY YEAR)

6. TO BE COMPLETED REGARDLESS OF AGE OF PATIENT (SEE REVERSE SIDE FOR INSTRUCTIONS)

IS THE PATIENT ENTITLED TO BENEFITS UNDER MEDICARE HOSPITAL INSURANCE (PART A)? ☐ YES EFF ______ /______ /______ (MONTH DAY YEAR) ☐ NO

IS THE PATIENT ENTITLED TO BENEFITS UNDER MEDICARE MEDICAL INSURANCE (PART B)? ☐ YES EFF ______ /______ /______ (MONTH DAY YEAR) ☐ NO

IF "YES" GIVE PATIENT'S IDENTIFICATION # (FROM MEDICARE ID CARD) ______________

7. I CERTIFY THE ABOVE IS COMPLETE AND CORRECT AND THAT I AM CLAIMING BENEFITS ONLY FOR CHARGES INCURRED BY THE PATIENT NAMED ABOVE.

Authorization is hereby given to any hospital, physician, or other Provider or other provider which participated in any way in my care and treatment to release to the Blue Cross and Blue Shield of Texas Plan which the Plans in their judgment deem necessary to the adjudication of this claim.

______________ Signature of Insured (Employee or Retiree) ______________ Date ______________ Telephone Number

Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

ITEMIZED BILL(S) FOR COVERED SERVICES AND SUPPLIES MUST BE ATTACHED

SEE INSTRUCTIONS ON REVERSE SIDE AND REFER TO THE CLAIMS FILING INSTRUCTIONS IN THE BENEFIT BOOKLET

Please submit your claim(s) with original bill(s) you received from the Provider or with the Provider's original signature on the attached bill(s).

Blue Cross and Blue Shield of Texas
P.O. Box 660044
Dallas, TX 75266-0044
1-800-252-8039

1081.020-302

HealthSelect administered by Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

INSTRUCTIONS

IMPORTANT: DO NOT FILE THIS FORM IF YOUR PHYSICIAN IS SUBMITTING HIS CHARGES TO BLUE CROSS AND BLUE SHIELD.

PLEASE COMPLETE EVERY ITEM ON CLAIM FORM.

1.	SUBSCRIBER'S NAME AND ADDRESS	Please show the subscriber's name exactly as it appears on the Blue Cross and Blue Shield Identification card and specify the current address including the ZIP code.
	PATIENT'S NAME	Use patient's full name. No nicknames, please.
	FROM IDENTIFICATION CARD	Insert identification number as shown on your recent identification card.
	PATIENT'S SEX, RELATIONSHIP OF PATIENT TO SUBSCRIBER	Check appropriate box in each block. If "OTHER" box is checked — Please explain relationship of PATIENT to subscriber.
	BIRTHDATE	Show patient's date of birth.
2.	DIAGNOSIS OR SYMPTOMS OF ILLNESS OR INJURY	A brief description will suffice.
3.	TREATMENT (INJURY, ILLNESS, PREGNANCY)	Enter either a 1,2, or 3 for appropriate treatment in box and specify Date of Injury (accident), Date of Illness, or Pregnancy (date of conception).
4.	IF INJURY	Give answer to question regarding motor vehicle.
	IF ILLNESS OR INJURY IS IN ANY WAY WORK CONNECTED	Check appropriate box and enter name and address of employer.
5.	OTHER GROUP INSURANCE	Please check appropriate box. If "yes," complete the required information.
6.	ALL OR PART OF CHARGES COVERED BY GOVERNMENT PROGRAM	Specify "yes" or "no" if you are covered under Medicare. 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.
7.	SUBSCRIBER'S SIGNATURE, DATE AND TELEPHONE NUMBER	Please sign and date this form and attach your physician's itemized letterhead statement(s). The itemized statement(s) should contain:

Itemized Bills Cannot Be Returned

Joseph Warowes
102 West 35th Street
Healthville, U.S.A.

Dayton Penridge, M.D.
101 Fourth Street
Healthville, U.S.A.

For Professional Services Rendered To:
Virginia E. Warowes

7/1/71	Office Care	$XXX
	Examination	XXX
	Cortisone Injection	
7/1/71	~~Examination at Home~~	~~XXX~~
7/1/71	Physical Therapy	XXX

1. NAME OF THE PATIENT RECEIVING THE SERVICES OR SUPPLIES

2. DATE EACH SERVICE OR SUPPLY WAS PROVIDED

3. DESCRIPTION OF THE SERVICES OR SUPPLIES PROVIDED

4. NAME OF THE PERSON OR ORGANIZATION PROVIDING THE SERVICES OR SUPPLIES.

5. CHARGE FOR EACH SERVICE OR SUPPLY

PLEASE CROSS OUT THOSE CHARGES WHICH WERE INCLUDED ON A PREVIOUS CLAIM.

BILLS FOR PRIVATE DUTY NURSING SERVICE

Service must show the professional status of the nurse (R.N. — Registered Nurse, L.V.N. — Licensed Vocational Nurse), the nurse's license number, and must include a statement from your physician indicating medical necessity and daily nurse's progress notes.

THIS COMPLETED FORM, TOGETHER WITH THE ITEMIZED BILLS SHOULD BE SUBMITTED TO:

Blue Cross and Blue Shield of Texas
P.O. Box 660044
Dallas, TX 75266-0044
1-800-252-8039

For additional copies of this form call the Customer Service number listed above, or download the form from the HealthSelect Web site at www.bcbstx.com/hs