

## **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).

		PATIENT'S NAME		
NAME OF SUBSCRIBER (Employee or Retiree)				
		GROUP NUMBER	SUBSCRIBER IDENTIFICATION	
STREET		38000	(AS SHOWN ON YOUR IDENTIFICATION CARD)	
CITY		SEX 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 ILLNESS (DATE OF FIRST SYMPTOM) OR Month Day Year  (ENTER EITHER 1,2, OR 3) PREGNANCY (DATE OF CONCEPTION)			
4.	IF INJURY, WAS MOTOR VEHICLE INVOLVED?			
	WAS ILLNESS OR INJURY WORK CONNECTED?	NAME AND ADDRESS	OF EMPLOYER	
5. IS PATIENT COVERED UNDER ANY OTHER HEALTH BENEFITS PLAN HELD BY REAS (IF "YES" COMPLETE THE REMAINDER OF THIS SECTION)			OR EMPLOYMENT? NO	
	NAME OF INSURING COADDRESS			
	NAME OF POLICY HOLDERB	BIRTH DATE / / SEX DEFINALE		
	EMPLOYER'S NAMEE			
6.	TO BE COMPLETED REGARDLESS OF AGE OF PATIENT (SEE REVERSE S	LESS OF AGE OF PATIENT (SEE REVERSE SIDE FOR INSTRUCTIONS)		
	IS THE PATIENT ENTITLED TO BENEFITS UNDER MEDICARE HOSPITAL INSURANCE (PART A)?			
	IS THE PATIENT ENTITLED TO BENEFITS UNDER MEDICARE MEDICAL INSURANCE (PART B)?			
	IF "YES" GIVE PATIENT'S IDENTIFICATION # (FROM MEDICARE ID CARD)			
7.	RTIFY THE ABOVE IS COMPLETE AND CORRECT AND THAT I AM CLAIMING BENEFITS ONLY FOR CHARGES INCURRED BY THE PATIENT ED 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

## **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.

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.

DIAGNOSIS OR SYMPTOMS OF ILLNESS OR INJURY

A brief description will suffice.

TREATMENT

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).

IF INJURY

Give answer to question regarding motor vehicle.

IF ILLNESS OR INJURY IS IN ANY

(INJURY, ILLNESS, PREGNANCY)

Check appropriate box and enter name and address of employer.

WAY WORK CONNECTED

ALL OR PART OF CHARGES COVERED

OTHER GROUP INSURANCE

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

BY GOVERNMENT PROGRAM

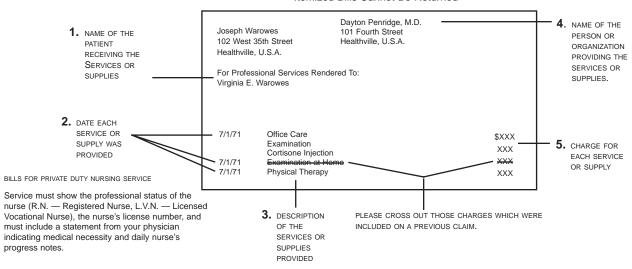
Specify "yes" or "no" if you are covered under Medicare. If "yes," show effective date and give Medicare identification number. MEDICARE ENROLLEES SHOULD INCLUDE A COPY(S) OF THE MEDICARE EXPLANATION OF BENEFITS FORM(S) (EOB) WITH THEIR ITEMIZED STATEMENTS.

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



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