BlueCross BlueShield of Texas

P.O. Box 660044
Dallas, Texas 75266-0044

Claim Form to Pay Insured/Subscriber

Please Print or Type

Each item on this form needs to be completed.
Instructions for completion are listed on the reverse side.

1 Insured/Subscriber Name (Last, First, Middle Initial)

2 Group Number

Insured/Subscriber Identification Number (from ID card)

Mailing Address

Patient's Full Name (Last, First, Middle)

City & State Zip Code

Patient's Sex ☐ Male ☐ Female

Patient's Date of Birth Month Day Year _____ /_____ /____

Insured Employed? ☐ Yes ☐ No ☐ Retired

Date of Retirement Month Date Year / /

Patient's Relationship to Insured
1. ☐ Self 2. ☐ Spouse 3. ☐ Child 4. ☐ Other (explain) _____

3 Type of treatment received:
Check only one type and attach itemized statements. Please use a separate claim form for each different type of treatment.
***Please note:** Preventive care includes immunizations, routine well baby care, routine physical examinations, vision and hearing exams.

Month Day Year
☐ Injury — Date of Accident: _____ /_____ /_____
☐ Illness — Date of First Symptom: _____ /_____ /_____
☐ Pregnancy — Date of Conception: _____ /_____ /_____
☐ Preventive — Date of Service: _____ /_____ /_____

4 Describe: Diagnosis, Symptoms of Illness or Injury or explain Preventive or Routine care received.

_____

_____

_____

5 Was Illness or Injury work connected? ☐ Yes ☐ No

Name and Address of Employer

_____

6 If Injury, was motor vehicle involved? ☐ Yes ☐ No

_____

7 Is patient covered under any other Health Benefits Plan (besides Medicaid, Medicare or CHAMPUS)? ☐ Yes ☐ No

Insuring Co._____ Policy # _____

Address_____ Effective Date of Coverage Month Day Year _____/_____/_____

Employer_____ Sex ☐ Male ☐ Female (Insured) Birthdate (Insured) _____/_____/_____

Insured_____ Relationship to Patient_____

If the other coverage is primary, attach the other insurance company's Explanation of Benefits

8 Medicare — Is the Patient:

Month Day Year

a) Entitled to Benefits Under Medicare Hospital Insurance (Part A)? ☐ Yes ☐ No Effective _____/_____/_____

b) Entitled to Benefits Under Medicare Medical Insurance (Part B)? ☐ Yes ☐ No Effective _____/_____/_____

c) Entitled to Benefits Under Medicare due to a disability? ☐ Yes ☐ No Effective _____/_____/_____

Patient's Medicare Identification No. (From Medicare ID Card)_____

9 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, Dentist, Provider, Insurance Carrier or other entity to give Blue Cross and Blue Shield of Texas, upon request, any medical information which the Plans in their judgment deem necessary to the adjudication of this claim. 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.

_____ Signature of Insured

_____ Date

_____ Daytime Telephone Number

Itemized Bill(s) for Covered Services and Supplies must be attached

(See Instructions on Reverse Side)

Instructions

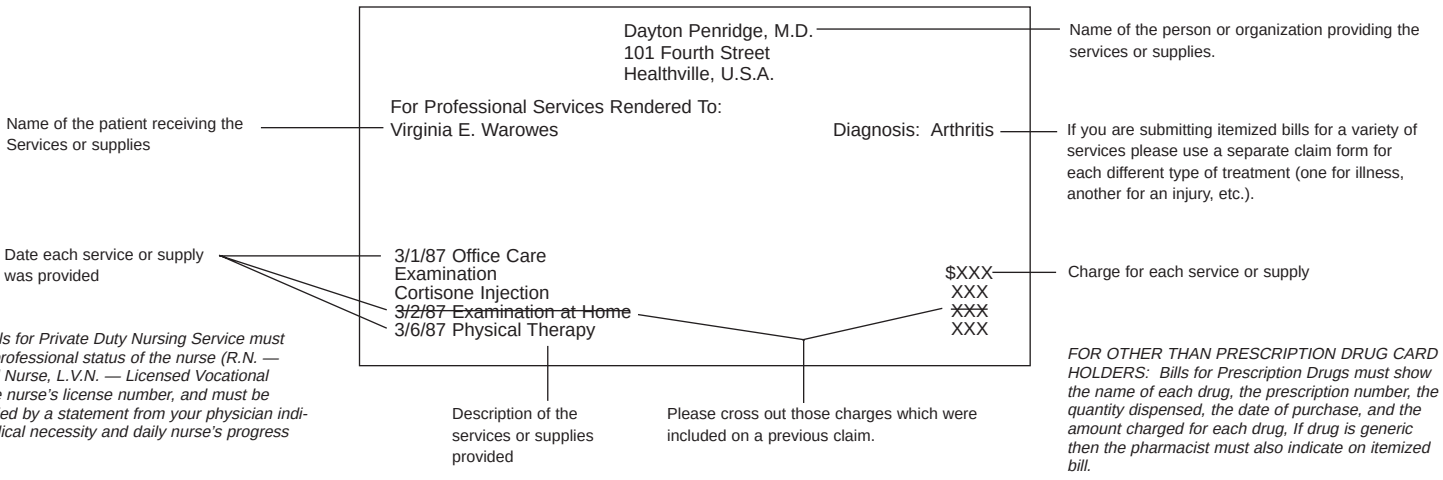
Important: Do Not file this form if your Provider of Service is submitting these charges to Blue Cross and Blue Shield of Texas.

Please complete every item on claim form.

1 Insured's/Subscriber's Name, Address and Employment Status	Please show the insured's/subscriber's name exactly as it appears on the Blue Cross and Blue Shield of Texas identification card and specify the current address including the ZIP code. Check appropriate box indicating the insured's /subscriber's employment status. If retired, give date of retirement.
2 Patient Information	Make sure the group number and identification number are exactly as shown on the insured's identification card. List patient's full name; no nicknames or initials please. Check the appropriate blocks for the patient's sex and relationship to the insured. Ensure the patient's correct date of birth is shown.
3 Type of Treatment Received	Check only one treatment type (injury, illness, pregnancy or preventive care) and specify date of injury, date of first symptom, date of conception or date preventive care was received. You may attach multiple itemized statements if they are for one type of treatment (example: illness only, preventive care only).
4 Diagnosis or Symptoms of Illness or Injury	Give diagnosis or a brief description of symptoms. If preventive care services were received, state the type of care (routine physical, hearing exam, vision exam or immunization diagnosis, etc.).
5 If Illness or Injury is in any way work related	Check appropriate box and enter name and address of employer.
6 If Motor Vehicle Injury	Check appropriate box.
7 Other Insurance	Please check appropriate box. If "yes," complete the required information.
8 Medicare Information	Please check appropriate box concerning Medicare eligibility. 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 unless patient is actively employed and requires group coverage to pay primary.
9 Insured's Signature, Date and Daytime Telephone Number	Please sign and date this form and attach your physician's itemized letterhead statement(s). The itemized statement)s) should contain all the information shown in the following example:

Itemized Bills Cannot Be Returned

Example of Itemized Bill



This completed form, together with the itemized bills should be submitted to:

Blue Cross and Blue Shield of Texas
P.O. Box 660044
Dallas, Texas 75266-0044

Additional copies of this form may be obtained from your Employer, our nearest Blue Cross and Blue Shield Area Office, or the above address.