



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.	☐ Injury — Date of Accident:	Month Day Year ____ / ____ / ____
	☐ 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 # _____	Month	Day Year
Address _____	Effective Date of Coverage	____ / ____ / ____	
Employer _____	Sex ☐ Male ☐ Female	Birthdate	____ / ____ / ____
Insured _____	(Insured) Relationship to Patient	(Insured)	

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.
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Signature of Insured	Date	Daytime Telephone Number
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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

Dayton Penridge, M.D. 101 Fourth Street Healthville, U.S.A.		Name of the person or organization providing the services or supplies.
Name of the patient receiving the Services or supplies	For Professional Services Rendered To: Virginia E. Warowes	Diagnosis: Arthritis
Date each service or supply was provided	3/1/87 Office Care Examination Cortisone Injection 3/2/87 Examination at Home 3/6/87 Physical Therapy	Charge for each service or supply \$XXX XXX XXX XXX

NOTE: Bills for Private Duty Nursing 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 be accompanied by a statement from your physician indicating medical necessity and daily nurse's progress notes.

FOR OTHER THAN PRESCRIPTION DRUG CARD HOLDERS: Bills for Prescription Drugs must show the name of each drug, the prescription number, the quantity dispensed, the date of purchase, and the amount charged for each drug. If drug is generic then the pharmacist must also indicate on itemized bill.

Please cross out those charges which were included on a previous claim.

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.