

P.O. Box 660044 · Dallas, TX 75266-0044

Claim Form

☐ To pay Insured/Subscriber **OR**☐ To get in-network credit for your cash payment to a provider

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

Plea	ase print or type.	pict	.011	are fisted off the	reverse	. side.				
	Insured/Subscriber Name (Last, First, Middle Initial)			Group Number	Insured	l/Subscriber Ider	itification N	umber	(from ID card)	
	Mailing Address			Patient's Full Name (Last, First, Middle)						
1	City and State ZIP Code		2	Patient's Sex	Patient	t's Date of Birth	Month	Day	Year	
	Insured Employed? Date of Retirement: Month Day Year						/_		_/	
				Patient's Relationship t						
	Yes No Retired//	[Self Spouse Child 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: ☐ Illness — Date of first symptom: ☐ Pregnancy — Date of conception:		_	// // // // // // // // // // // // //	/_		
				\Box Preventive — Date of se						
Describe: Diagnosis, symptoms of illness or injury or explain preventive or routine care received.										
4										
5	Was illness or injury work connected? ☐ Yes ☐ No		Nam	e and address of employ	yer					
6	If injury, was a motor vehicle involved?								_	
	Is patient covered under any other health benefits plan (besides Medicaid, Medicare or CHAMPUS)? Yes No									
7	Month Day Year									
	Insurance Co			Effective data of co			,	,		
	Address									
	Insured name									
	Policy #			Date of birth of insi	//					
	If the other coverage is primary, attach the other insurance of	ompa	ny's	Explanation of Benefits	5.					
8	Medicare — Is the patient:					Mo	nth Da	У	Year	
	a) Entitled to benefits under Medicare insurance (Part A)?			☐ Yes ☐ No	Effective	e	/	/		
	b) Entitled to benefits under Medicare insurance (Part B)?			☐ Yes ☐ No	Effective	e	/_	/		
	c) Entitled to benefits under Medicare due to a disability?			☐ Yes ☐ No	Effective	e	/	/		
	Patient's Medicare Identification Number. (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. Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.									
	Signature of Insured			Date	Date		Daytime telephone number			
						1				
10	Total amount for ALL covered services and supplies received.					\$				
	Itemized Bill(s) for covered services and sup	Itemized Bill(s) for covered services and supplies must be attached. (See Instructions on reverse side.)								



Claim Form

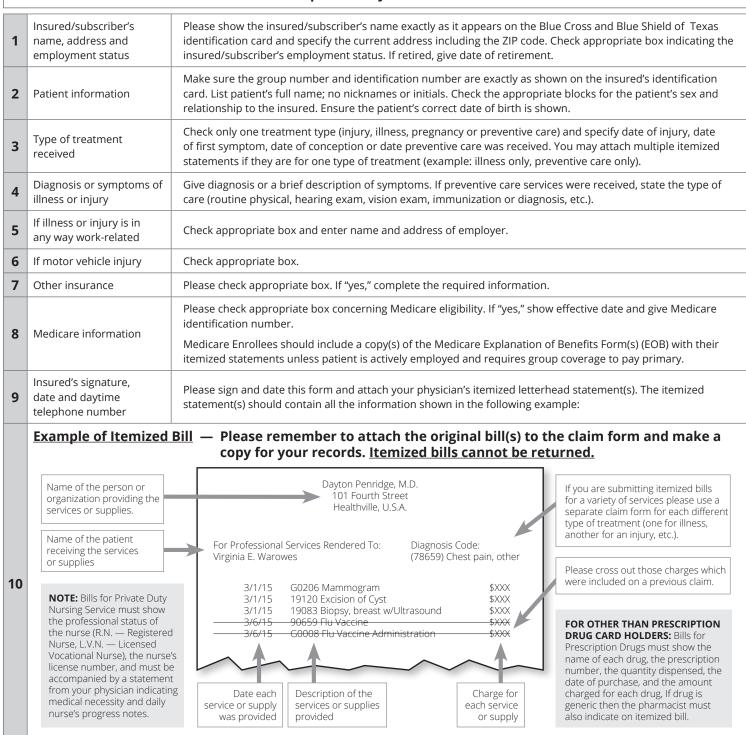
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INSTRUCTIONS

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.



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