

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)		Group Number 99254	Insured/Subscriber Identification Number (from ID card)					
	Mailing Address	Pat	ient's Full Name (Last,	First, Midd	le)				
	City & State Zip Code	Pat	ient's Sex	Patient's	Dato	of Rirth	Month	Day	Year
	Only & State Zip Gode	at	Male Female	lauents	Dale	OI BII II I	/	/	/
	Insured Employed? Date of Retirement Month Date Year	Pat	ient's Relationship to In	sured					· · · · · · · · · · · · · · · · · · ·
	Yes No Retired / / /	1.	Self 2. Spouse	3. Child	i 4.	Other (expla	in)		
3	Type of treatment received:	-	_				Month	Day	Year
	Check only one type and attach itemized statements. Please use a separate claim form for each different type		Injury — Date of Accident: Illness — Date of First Symptom:				/		
	of treatment. *Please note: Preventive care includes immunizations,		Pregnancy — D				/_		
	routine well baby care, routine physical examinations,		Preventive — Da		-				
	vision and hearing exams.			_					
4	Describe: Diagnosis, Symptoms of Illness or Injury or	r exp	lain Preventive or I	Routine o	care r	eceived.			
	Preventive Eye Care								· · · · · · · · · · · · · · · · · · ·
5	Was Illness or Injury work connected? Yes	No	Name and Add	dress of I	Emplo	ver			
	•					<u> </u>			
6	If Injury, was motor vehicle involved? Yes	No	7						
_	Is patient covered under any other Health Benefits Pl	lan (l	l Desides Medicaid	Medicare	or C	HAMPUS)	? Yes	N	0
	Insuring Co.		Policy #			-	Month	Day	Year
	Address							, /	/
	Employer			Female Birthdate					
	Insured		(Insured) Relationship to	(Insur					
			•		. D	_ f:ı _			
	If the other coverage is primary, attach the other insu	ranc	e company's Expla	ination o	Bene	ents	•		
8	Medicare — Is the Patient:		- /DI A)O	VĆ.	NI.	E (C 12	Month	Day ,	Year
a) Entitled to Benefits Under Medicare Hospital Insura b) Entitled to Benefits Under Medicare Medical Insura c) Entitled to Benefits Under Medicare due to a displace.				Yes		Effective		/	_/
			•	Yes		Effective		/	_/
	c) Entitled to Benefits Under Medicare due to a disa	•		Yes		Effective	-	/	_/
	Patient's Medicare Identification No. (From Medicare		·						
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 fir	nes a	and confinement in	state pr	ison.				
		_							
	Signature of Insured	_	Date			Daytime T	elephone l	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.

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. Insured's/Subscriber's Name, Address and Employment Status Check appropriate box indicating the insured's /subscriber's employment status. If retired, give date of retirement. Patient Information

Check appropriate box.

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.

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).

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,

Check appropriate box and enter name and address of employer.

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

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:

Insured's Signature, Date and Daytime Telephone Number

Type of Treatment

of Illness or Injury

way work related

Other Insurance

If Motor Vehicle Injury

Medicare Information

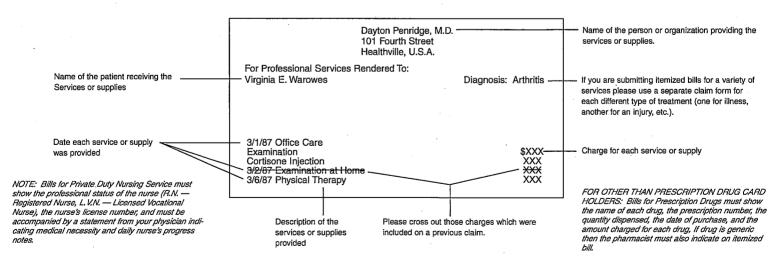
Diagnosis or Symptoms

If Illness or Injury is in any

Received

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.