

MEDICAL CLAIM FORM

• • • IMPORTANT: PLEASE READ THE INSTRUCTIONS ON THE BACK OF THIS FORM • • •

• • Your Physician does not need to sign this form • • Please complete and sign a <u>separate form</u> for each patient

		PATIEN	IT INFOR	MATION				
1.	Patient's Name (No nicknames pleas	3.	3. Patient's Date of Birth					
	First Adv Local			Month / Day / Year				
	First M	ll Las	4.	Identificati	ion Number as Sh	own on I.D. Card		
2.	Name as Shown on I.D. Card							
			5.	5. Patient's Sex 6. Patient's Relationship to Em			ionship to Employee	
	First MI Last			☐ Male ☐ Female ☐ Self ☐ Child ☐ Spouse ☐ Othe				
7.	Current Mailing Address							
	Street	Cìţy				State	Zip	
	Current Telephone Numbers: Home Office (optional) Area Code							
Area Code (optional) Area Code Payments and Explanation of Benefits will be sent to the most current address listed in our files.								
0	OTHER HEALTH INSURANCE INFORMATION Is patient covered under any other health insurance plan? Yes No							
8.	If yes, complete the following: Name of Policyholder							
	Name of Employer (if group coverage)					Middle		
	Name and Address of Insuring Comp	Name						
		Street	Street					
	Policy #	City			Sta	ite	Zip	
9.	Is patient covered under Medicare P							
	Medicare Part A ☐ Yes ☐ No Effective Date/_ Month			/				
	Medicare Part B ☐ Yes ☐ No Effective Date/_ Month			/ If no, please enter effective date of retiren		date of retirement/		
	Month Day Year termination. Medicare Identification #					Mon	h Day Year	
	CONDITION AND TREATMENT							
10.	10. Was condition related to: Employment □ Auto Accident □ Other Accident/Injury □ Illness □							
11.	If Accident/Injury, give date.	Describe th	e nature of accide	ent or illness and list	symptoms.			
	Month / Day / Year							
		AU	THORIZA	TION				
l ce	ertify that the information I have given tient identified above. I authorize the re	is accurate to the best of m	y knowledg	e and that I	am claiming bene ocess this claim	efits only for the cha	rges incurred by the	

Signature_

Date_

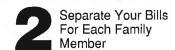
WHEN SHOULD YOU USE THIS FORM?

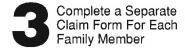
This form is designed to help you file itemized medical bills for you or an enrolled family member. You should not submit this form if your healthcare provider has filed a claim for you. Retain your receipt for your records.

PLEASE REVIEW YOUR MEDICAL BILLS AND FILE CLAIMS AT LEAST ONCE A MONTH TO ENSURE THE TIME-LY PROCESSING OF YOUR CLAIMS.

CLAIMS FILING INSTRUCTIONS







- Attach Itemized Medical Bills for the patient named on the form. Each itemized bill must include the patient's name; the healthcare provider's name and address; the date of each service; descriptions and charge for each service.
- If you are covered under any other health insurance or under Medicare, you must attach a copy of the Explanation of Benefits indicating their payment.

DID YOU

- "*** USE A SEPARATE CLAIM FORM FOR EACH FAMILY MEMBER?
- **** COMPLETE EACH SECTION OF THE CLAIM FORM ENTIRELY?
- **** COPY YOUR IDENTIFICATION NUMBER DIRECTLY FROM YOUR ID CARD?
- **** ATTACH THE ORIGINAL ITEMIZED BILL(S) FROM THE PROVIDER THAT DESCRIBES ALL SERVICES RENDERED AND INCLUDES DATES OF SERVICE AND CHARGES?
- **** KEEP A COPY FOR YOUR RECORDS?

Please forward your completed form to:

Blue Cross & Blue Shield of Mississippi P. O. Box 23071 Jackson, Mississippi 39225-3071 For further information or additional copies of this form, please contact our Customer Service Department. (1-800-709-7881)

Claims Administered by:



Committed to a Healthier Mississippi.