



# University Of California Member Claim Form

Send completed claim forms and written inquiries to:  
Anthem Blue Cross  
P.O. Box 60007  
Los Angeles, CA 90060-0007  
Or call: (888) 209-7975

Please use a separate claim form for each patient. Your cooperation in completing all items on the claim form and attaching all required documentation will help expedite quick and accurate processing.

### PLEASE TYPE or PRINT · SEE REVERSE SIDE FOR COMPLETE INSTRUCTIONS

PATIENT INFORMATION				SUBSCRIBER INFORMATION (on ID Card)			
NAME Last		First Middle Initial		SUBSCRIBER ID NUMBER		GROUP NUMBER	
BIRTHDATE	SEX <input type="checkbox"/> M <input type="checkbox"/> F	RELATION TO SUBSCRIBER <input type="checkbox"/> Self <input type="checkbox"/> Adult Dependent <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Other		U	NAME Last First Middle Initial		
DOES THE PATIENT HAVE OTHER HEALTH INSURANCE COVERAGE? <input type="checkbox"/> YES <input type="checkbox"/> NO				ADDRESS			
NAME OF OTHER HEALTH INSURANCE COMPANY				CITY		STATE	ZIP CODE
POLICY NUMBER				HOME PHONE NO. ( )		WORK PHONE NO. ( )	

### MEDICAL INFORMATION

**HEALTH CARE SERVICES:** Use this section to report any COVERED health service which has not already been reported to your Anthem Blue Cross Plan by the service provider (the physician, clinic, pharmacy, ambulance company, private duty nurse, etc.) Attach an itemized bill or photocopy. Please be sure that duplicate bills are not submitted.

Was this medical expense the result of an accident? .....  YES  NO

Was this condition or injury job related? .....  YES  NO

Have you filed for Workers' Compensation? .....  YES  NO

On what day did this injury or accident occur? ..... Month: \_\_\_ Day: \_\_\_ Year: \_\_\_

Have you been treated for the same condition within the last 24 months? .....  YES  NO

If yes, indicate date you were last treated: ..... Month: \_\_\_ Day: \_\_\_ Year: \_\_\_

DATE OF SERVICE (Mo/Day/Yr)	PROVIDER OF SERVICE (Name of Doctor, Lab, Pharmacy Amb. Co., etc.)	SERVICE RENDERED (Office Visit, Prescription, X-ray, etc.)	ILLNESS OR DIAGNOSIS	TOTAL

If the bill is from a Licensed Clinical Social Worker; Marriage, Family and Child Counselor; Audiologist; or Occupational, Physical, or Speech Therapist; what is the name of the physician who ordered the service?

Dr. \_\_\_\_\_

GRAND TOTAL  
\$

I certify that the information on this Member Claim Form is true and correct to the best of my knowledge. I authorize the release of any medical information necessary to process this claim.

You or the provider of service must send properly and fully completed claim forms to the claims administrator within 90 days of the date you receive the service or supply for which a claim is made. If is not reasonably possible to submit the claim within that time frame, an extension of up to 12 months will be allowed. We are not liable for the benefits of the plan if you do not file claims within the required time period.

**X** \_\_\_\_\_

SIGNATURE OF SUBSCRIBER

\_\_\_\_\_

DATE

## University of California Member Claim Form

This form applies to members enrolled in the Plus, PPO, High Option and Core plans.

**Core Members:** All Core members should use this form for all health care services, including prescription drug claims. Please include your receipt for the prescription.

Dear UC Member:

Usually, health care providers will bill us for services provided to you and your enrolled dependents. We prefer this procedure because you are not bothered with claim forms and we often need more details than are ordinarily provided on bills to patients.

Sometimes however, a provider may not bill us or may send the bill directly to you. In either instance, we have no way of knowing about your claim. This Member Claim Form was developed to enable you to notify us of any covered health service for which we have not already been billed. Please read the following instructions about how to report health care services.

### HOW TO USE THIS FORM

Submit this form for reimbursement of healthcare services (for you and your enrolled dependents) that have not been submitted to Anthem Blue Cross.

Please use a separate claim form for each dependent requesting reimbursement. Completing all items on the claim form and attaching all required documentation will help expedite the accurate processing of your claim.

### PATIENT INFORMATION

### SUBSCRIBER INFORMATION (on ID Card)

Use this section to identify the patient and subscriber. Some of this information may be found on your Anthem Blue Cross card.

### MEDICAL INFORMATION

**HEALTH CARE SERVICES:** Use this section to report any COVERED health service which has not already been reported to this Anthem Blue Cross Plan by the service provider (the physician, clinic, pharmacy, ambulance company, private duty nurse, etc.) Attach an itemized bill or photocopy. Please be sure that duplicate bills are not submitted.

DATE OF SERVICE (Mo/Day/Yr)	PROVIDER OF SERVICE (Name of Doctor, Lab, Pharmacy Amb. Co., etc.)	SERVICE RENDERED (Office Visit, Prescription, X-ray, etc.)	ILLNESS OR DIAGNOSIS	TOTAL
2/9/02	John Wang, M.D.	Office Visit	Bronchitis	\$35.00
2/9/02	Pat Fogarty, M.D.	X-ray	Strain	\$57.00
2/9/02	Long's Drugs	Prescription	Infection	\$32.00
<b>GRAND TOTAL</b>				<b>\$124.00</b>

### BILLS MUST BE ITEMIZED

Insure that your itemized bill contains all of the required information listed below. Cancelled checks, cash register receipts and non-itemized "balance due" or "balance forward" statements cannot be processed. Each itemized bill must include:

- Name of patient
- Name and address of provider (doctor, hospital, laboratory, pharmacy, ambulance service, etc.)
- Service provided
- Date of service
- Amount charged for each service
- Diagnosis

### ADDITIONAL REQUIREMENTS

In addition to the required information listed above, the following apply to the services below:

#### REGISTERED AND LICENSED VOCATIONAL NURSES:

- Hours and dates of service
- Location of service (address and name of hospital)
- Written documentation of physician's referral (must include the state license number, plan of treatment and estimated duration of treatments)

#### PROSTHETIC DEVICES, APPLIANCES OR DURABLE MEDICAL EQUIPMENT:

- Doctor's orders or prescription
- Purchase price

#### AMBULANCE

- Pick-up and delivery points
- Number of miles