

County Health Pool Dental Claim Form

Subscriber Submitted Claim

One patient and one provider per claim form



PATIENT/SUBSCRIBER INFORMATION			
1. Member number		2. Group no.	
3. Patient's name (Last, First, MI) (Please print)		4. Patient birth date 	5. Patient gender <input type="checkbox"/> Male <input type="checkbox"/> Female
6. Subscriber name		7. Patient relationship to subscriber self spouse child other	
8a. Subscriber address street	8b. City	8c. State	8d. Zip code

COORDINATION OF BENEFITS INFORMATION - ANSWER "YES" OR "NO" TO ALL QUESTIONS		
9. Is Patient Covered By Any Other Group Health Benefit Plan? (IF NO GO TO QUESTION 11) <input type="checkbox"/> Yes <input type="checkbox"/> No		
10a. Name of policyholder	10b. Name and address of Insurance Co.	10c. Policy no.
11. Is patient eligible for Part A and/or Medicare? (IF NO GO TO QUESTION 12) PART A <input type="checkbox"/> Yes <input type="checkbox"/> No PART B <input type="checkbox"/> Yes <input type="checkbox"/> No		11a. Medicare no.
12. Illness or symptoms - for reimbursement	12a. Diagnosis or Injury Date	
13. Name of provider or hospital facility of service	14. If We Have Questions, Who May We Contact? Name: Phone No:	
15. If place of service was outpatient hospital, provide name of hospital facility		

PLEASE COMPLETE THE FOLLOWING AS A SUMMARY OF THE ITEMIZED BILLS YOU HAVE ATTACHED TO THIS CLAIM FORM			
16. Date of service	17. Place of service*	18. Charge for service	19. Briefly describe the service(s) you received

*Place of Service H = home NH = Nursing Home P = Pharmacy L = Lab

Tax ID 84-2222222	20. Total Charges for which You are Requesting Consideration of Payment \$
21. I CERTIFY TO THE ACCURACY AND COMPLETENESS OF ALL INFORMATION REPORTED BY ME ON THIS FORM AND AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM.	
Signature _____	Date _____

FULL SIGNATURE AND DATE REQUIRED ON EACH FORM INCOMPLETE FORMS MAY DELAY PROCESSING. PLEASE ENSURE ALL FIELDS ARE ANSWERED.

SUBSCRIBER CLAIM FILING INFORMATION (HOW TO FILE)

Be sure to ask your provider of care if he/she bills a statement to Anthem Blue Cross and Blue Shield. Please submit statements only if the provider does not bill us directly. To receive benefits for RX, or for services by a provider who does not bill us directly, complete the claim form, attach itemized bills, and mail the white copy to Anthem Blue Cross and Blue Shield, P.O. Box 5747, Denver, Colorado 80217-5747.

Keep a duplicate copy of your itemized bills as they will not be returned to you. **This claim may be returned to you if all required information is not present.**

CLAIM FILING INSTRUCTIONS (CORRESPONDS TO NUMBERED ITEMS ON CLAIM FORM)

A separate claim form for each family member and each provider of care must be submitted.

ITEM NO.

1-9 Please complete all blocks. All fields required.

10 Coordination of additional Insurance.

11 Medicare eligibility.

12 Illness or symptoms for reimbursement.

13 Indicate the name of the physician, pharmacy, hospital or other institutional facility who has billed for services provided to the patient. Only one provider per form (however, multiple pharmacy bills may be attached to one claim form.)

14 Name & telephone number, whoever can help provide addition information if required.

15 Place of service for outpatient hospital, provider name of hospital facility

16 Use a separate line for each date of service and receipt.

17 Write the appropriate code to indicate the place of service by using the legend below this section.

18 Indicate the total charge for each service.

19 Briefly indicate the type of service, i.e. lab, X-ray, surgery, therapy, cast, stitches, etc.

20 This amount represents the total of all charges to be considered for benefit.

21 Your signature attests to the accuracy and completeness of all information on the claim and the attachments and authorizes the release of your medical records by the provider to our office if necessary.

REQUIRED INFORMATION

Itemized Bills: Summarizing the services may help us better understand the attachments if they are not clear. The attached itemized bills must include the provider name, patient's name, date of service, detailed description of service, and amount charged for that service. These must be valid documents from the provider.

Psychotherapy: Length and type of session (group or individual). Name and professional status of the individual conducting the session.

Prescription Drugs: Patient's name, pharmacy name and address, purchase date, drug name, prescription number and charge. The bill or receipt must be issued by the pharmacy.

HELPFUL HINTS

If you have questions or need assistance, contact Anthem Blue Cross and Blue Shield Customer Service.

To reduce the possibility of small billings getting lost or separated, it would be helpful if you attach these to an 8 1/2x11 piece of paper.

We encourage you to file claims within 90 days of the service date. Please refer to your Benefit Certificate for specific timely filing limitations.

File only if the provider has not.

Important: If the services for this claim were provided by a participating physician or hospital, the benefit payment will go to the provider. However, if you paid this participating provider in full, attach a copy of your cancelled check or receipt and we will direct the benefit payment to you. Indicate "PAID IN FULL" under item 24.

A complete description of your benefits, as well as limitations and exclusions applicable thereto, is available in the Benefit Certificate. Final interpretation of any and all provisions of the program is governed by the Benefit Certificate.