



An Independent Licensee of the Blue Cross and Blue Shield Association

FILL OUT A SEPARATE FORM FOR EACH PATIENT.

Use this form to file a claim for any eligible medical expenses when your physician or other provider does not file a claim. Please **print** clearly with black ink or **type**.

1. Patient's Name (only one Patient per form)																			
Last _____		First _____	Middle Initial _____																
2. Contract Number as shown on your I.D. Card (include any letters, if applicable)		3. Group Number (as shown on I.D. Card) or Place of employment																	
_____		_____																	
4. Patient's Date of Birth		5. Patient's Sex																	
<table style="width:100%; border-collapse: collapse;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> <tr> <td style="text-align: center;">mm</td> <td style="text-align: center;">dd</td> <td colspan="4"></td> <td style="text-align: center;">yyyy</td> <td></td> </tr> </table>										mm	dd					yyyy		<input type="checkbox"/> Male <input type="checkbox"/> Female	
mm	dd					yyyy													
6. Patient's Relationship to Contract Holder																			
<input type="checkbox"/> Self <input type="checkbox"/> Child <input type="checkbox"/> Spouse <input type="checkbox"/> Other (explain) _____																			
7. Contract Holder Information (name as shown on your I.D. card)																			
Last _____		First _____	Middle Initial _____																
Street _____		() _____																	
City _____		State _____	Zip _____																
		Daytime telephone number and extension _____																	
8. Is patient covered under any other group health insurance plan? (including any other Blue Cross and Blue Shield coverage).																			
<input type="checkbox"/> YES <input type="checkbox"/> NO If yes , complete the following:																			
Name of Policy Holder _____																			
Last _____		First _____	Middle Initial _____																
Name and Address of Insuring Company _____		I.D. Number _____																	
Is the patient entitled to Medicare benefits?		Policy Effective Date																	
Part A <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Part B <input type="checkbox"/> YES <input type="checkbox"/> NO		<table style="width:100%; border-collapse: collapse;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> <tr> <td style="text-align: center;">mm</td> <td style="text-align: center;">dd</td> <td colspan="4"></td> <td style="text-align: center;">yyyy</td> <td></td> </tr> </table>										mm	dd					yyyy	
mm	dd					yyyy													
		Medicare Number _____																	
9. Was condition related to:																			
a. Patient's Employment		<input type="checkbox"/> YES <input type="checkbox"/> NO (If yes , give date of accident or onset of illness):																	
b. Auto Accident		<input type="checkbox"/> YES <input type="checkbox"/> NO																	
c. Other Accident/Injury		<input type="checkbox"/> YES <input type="checkbox"/> NO																	
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mm	dd					yyyy													
10. Diagnoses (type of illness or injury)		11. Ordering Physician																	
_____		Phone () _____																	
_____		Last Name _____																	
_____		First Name _____																	
		Address _____																	
		City _____																	
		State _____																	
		Zip _____																	

INSTRUCTIONS: Attach the original bill or statement from the physician or supplier and **keep a copy for your records.** Make sure the bill contains all required information (see back of form for required information). **Sign this form.**

I, the undersigned, furnished the above information to enable Blue Cross and Blue Shield of Alabama to consider this claim for payment, and I certify that such information is true and correct and that the expenses were incurred by the above named patient. **I understand that any payment will be made to me.**

Signature _____ Date _____

SEE BACK OF CLAIM FORM FOR EASY CLAIM FILING INSTRUCTIONS

FILING YOUR CLAIM IS EASY

1. Fill out the Medical Expense Claim form (include all requested information).
2. Attach the bill (or clear copy of the bill) to this form.

Your bill should include the following information: (do not attach a balance forward bill)

- Patient's full name.
- Date of treatment.
- A description of the treatment provided (i. e. office visit, x-ray, surgery etc.)
- A diagnosis (type of illness or injury).
- Charge for each treatment.
- Place of treatment (i.e. doctor's office, hospital, one day surgery clinic, etc.)
- Date of accident (if applicable).
- Any Medical Equipment and/or supplies purchased. (Supply the invoice and be sure to complete box 11, Ordering Physician, on the front of this form.)

Note: The above information is usually provided on an itemized bill from the provider.)

THIS INFORMATION IS NEEDED TO PROPERLY FILE PRESCRIPTION DRUG CLAIMS.

(NOTE: FOR FILING POINT-OF-SALE PRESCRIPTION DRUG CLAIMS, USE CLAIM FORM CL-94.)

Attach the receipt or legible copy of receipt given by the pharmacist. The receipt should list the following information:

- The patient's name.
- The National Drug Code (NDC).
- The name of the prescription drug and manufacturer.
- The amount of the prescription drug.
- The name of the Pharmacy along with the telephone number and address.
- The name of the Doctor that prescribed the drug.
- Please indicate on the receipt the reason for taking each prescription.

Members can mail the completed claim to:

**Blue Cross and Blue Shield of Alabama
Claims Department
Post Office Box 995
Birmingham, Alabama 35298-0001**

OR

Members can also fax claims to:

**205-220-2146
800-526-8529**