

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)	2 Group Number 059473	Insured/Subscriber Identification Number (from ID card)		
Mailing Address	Patient's Full Name (Last, First, Middle)			
City & State	Zip Code	Patient's Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Patient's Date of Birth	Month Day Year ____/____/____
Insured Employed? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Retired	Date of Retirement Month Date Year ____/____/____	Patient's Relationship to Insured 1. <input type="checkbox"/> Self 2. <input type="checkbox"/> Spouse 3. <input type="checkbox"/> Child 4. <input type="checkbox"/> Other (explain) _____		

3 Type of treatment received:
Check only one type and attach itemized statements.
Please use a separate claim form for each different type of treatment.
***Please note:** Preventive care includes immunizations, routine well baby care, routine physical examinations, vision and hearing exams.

<input type="checkbox"/> Injury — Date of Accident:	Month	Day	Year
<input type="checkbox"/> Illness — Date of First Symptom:	____/____/____		
<input type="checkbox"/> Pregnancy — Date of Conception:	____/____/____		
<input type="checkbox"/> Preventive — Date of Service:	____/____/____		

4 Describe: Diagnosis, Symptoms of Illness or Injury or explain Preventive or Routine care received.

5 Was Illness or Injury work connected? Yes No Name and Address of Employer

6 If Injury, was motor vehicle involved? Yes No

7 Is patient covered under any other Health Benefits Plan (besides Medicaid, Medicare or CHAMPUS)? Yes No

Insuring Co. _____	Policy # _____	Month	Day	Year
Address _____	Effective Date of Coverage	____/____/____		
Employer _____	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Birthdate	____/____/____	
Insured _____	(Insured)	(Insured)		
	Relationship to Patient	_____		

If the other coverage is primary, attach the other insurance company's Explanation of Benefits

8 Medicare — Is the Patient:

a) Entitled to Benefits Under Medicare Hospital Insurance (Part A)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Effective	Month	Day	Year
b) Entitled to Benefits Under Medicare Medical Insurance (Part B)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Effective	____/____/____		
c) Entitled to Benefits Under Medicare due to a disability?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Effective	____/____/____		

Patient's Medicare Identification No. (From Medicare ID Card) _____

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, Inc., upon request, any medical information which the Plans in their judgment deem necessary to the adjudication of this claim.

Signature of Insured _____ Date _____ Daytime Telephone 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.

- | | |
|---|--|
| 1 Insured's/Subscriber's Name, Address and Employment Status | 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. Check appropriate box indicating the insured's /subscriber's employment status. If retired, give date of retirement. |
| 2 Patient Information | 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. |
| 3 Type of Treatment Received | 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). |
| 4 Diagnosis or Symptoms of Illness or Injury | 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, etc.). |
| 5 If Illness or Injury is in any way work related | Check appropriate box and enter name and address of employer. |
| 6 If Motor Vehicle Injury | Check appropriate box. |
| 7 Other Insurance | Please check appropriate box. If "yes," complete the required information. |
| 8 Medicare 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. |
| 9 Insured's Signature, Date and Daytime Telephone Number | 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: |

Itemized Bills Cannot Be Returned

Example of Itemized Bill

	<table border="0" style="width: 100%;"> <tr> <td style="width: 60%; text-align: center;">Dayton Penridge, M.D. 101 Fourth Street Healthville, U.S.A.</td> <td style="width: 40%;"></td> </tr> <tr> <td style="text-align: center;">For Professional Services Rendered To: Virginia E. Warowes</td> <td style="text-align: right;">Diagnosis: Arthritis</td> </tr> <tr> <td style="text-align: center;">3/1/87 Office Care Examination Cortisone Injection 3/2/87 Examination at Home 3/6/87 Physical Therapy</td> <td style="text-align: right; vertical-align: bottom;">\$XXX XXX XXX XXX</td> </tr> </table>	Dayton Penridge, M.D. 101 Fourth Street Healthville, U.S.A.		For Professional Services Rendered To: Virginia E. Warowes	Diagnosis: Arthritis	3/1/87 Office Care Examination Cortisone Injection 3/2/87 Examination at Home 3/6/87 Physical Therapy	\$XXX XXX XXX XXX	<p>Name of the person or organization providing the services or supplies.</p> <p>If you are submitting itemized bills for a variety of services please use a separate claim form for each different type of treatment (one for illness, another for an injury, etc.).</p> <p>Charge for each service or supply</p>
Dayton Penridge, M.D. 101 Fourth Street Healthville, U.S.A.								
For Professional Services Rendered To: Virginia E. Warowes	Diagnosis: Arthritis							
3/1/87 Office Care Examination Cortisone Injection 3/2/87 Examination at Home 3/6/87 Physical Therapy	\$XXX XXX XXX XXX							
<p>Name of the patient receiving the Services or supplies</p> <p>Date each service or supply was provided</p>	<p>Description of the services or supplies provided</p> <p>Please cross out those charges which were included on a previous claim.</p>	<p><i>FOR OTHER THAN PRESCRIPTION DRUG CARD HOLDERS: Bills for Prescription Drugs must show the name of each drug, the prescription number, the quantity dispensed, the date of purchase, and the amount charged for each drug. If drug is generic then the pharmacist must also indicate on itemized bill.</i></p>						

NOTE: Bills for Private Duty Nursing Service must show the professional status of the nurse (R.N. — Registered Nurse, L.V.N. — Licensed Vocational Nurse), the nurse's license number, and must be accompanied by a statement from your physician indicating medical necessity and daily nurse's progress notes.

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**

For additional copies of this form visit www.txhealthpool.org or call (888) 398-3927.