

Claim Form to Pay Insured/Subscriber

P.O. Box 655924 • Dallas, TX 75265-5924

Each item on this form needs to be completed. Instructions for completion are listed on the reverse side.

Please print or type.

	Insured/Subscriber Name (Last, First, Middle Initial)			Group Number	Insured/Subscriber Identification Number (from ID card)					
	Mailing Address			Patient's Full Name (Last, First, Middle)						
1	City and State ZIP Code	2	2	Patient's Sex	Patient's	Date of Birth	Month	Day	Year	
	Insured Employed? Date of Retirement:		ŀ	Patient's Relationship to Ins	urod	-		./	_/	
	Month Day Year			Self Spouse Child Other (explain)						
	Yes No Retired//			□ Self □ Spouse □ Child □ Other (explain)						
3	Type of treatment received:						Month	Day	Year	
	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.			Injury — Date of accident:				/	/	
			\square IIIness — Date of first symptom:				////			
			☐ Pregnancy — Date of conception: ☐ Preventive — Date of service:					/	/	
								/	/	
	Describe: Diagnosis, symptoms of illness or injury or explain preventive or routine care received.									
4										
-										
	Nome and address of amplayer									
5	Was illness or injury work connected? Yes No Name and address of employer									
6	If injury, was a motor vehicle involved?									
	Is patient covered under any other health benefits plan (besides Medicaid, Medicare or CHAMPUS)?									
7	Insurance Co.					ľ	Month	Day	Year	
	Address Effective date of coverage						/	,	,	
								·		
	Insured name Date of birth of insured						/	,	,	
	Policy # Relationship to patient									
If the other coverage is primary, attach the other insurance company's Explanation of Benefits.										
8	Medicare — Is the patient:					1	Month	Day	Year	
	a) Entitled to benefits under Medicare insurance (Part A)?			☐ Yes ☐ No	Effective		/_	/_		
	b) Entitled to benefits under Medicare insurance (Part B)?			☐ Yes ☐ No	Effective		/_	/_		
	c) Entitled to benefits under Medicare due to a disability?			☐Yes ☐ No	Effective		/_	/_		
	Patient's Medicare Identification Number. (From Medicare ID card)									
	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 Oklahoma, upon request, any medical information. Any person who knowingly presents a false or fraudulent claim for									
9	payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.									
	·									
	Signature of Insured			Date	₽ate		Daytime telephone number			
	Total amount for ALL covered services and supplies received.					\$				
10	Itemized Bill(s) for covered services and supplies must be attached. (See Instructions on reverse side.)									
	iterinzed biii(a) for covered activities and supplies must be attached. (Bee instructions on reverse side.)									

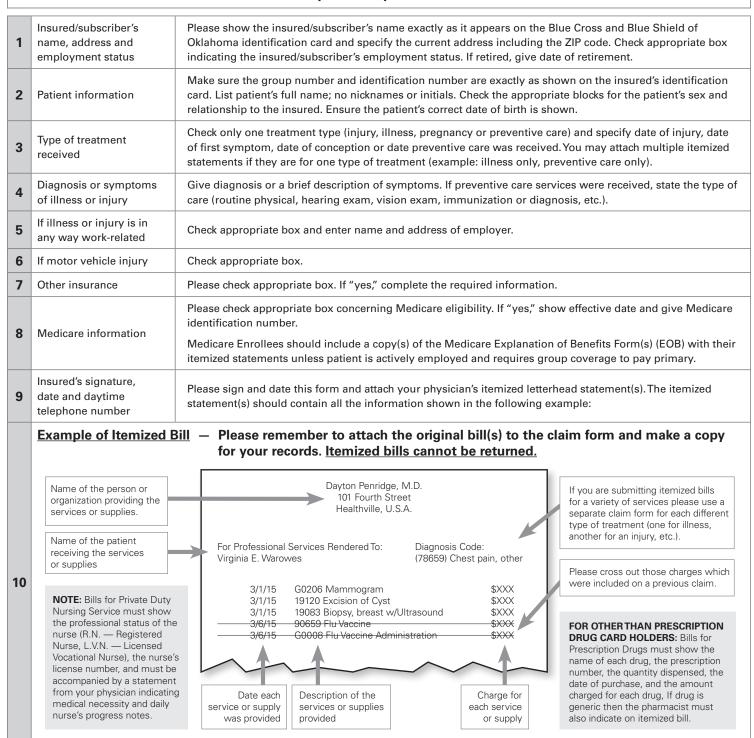


Claim Form to Pay Insured/Subscriber

INSTRUCTIONS

Important: DO NOT file this form if your Provider of Service is submitting these charges to Blue Cross and Blue Shield of Oklahoma.

Please complete every item on claim form.



This completed form, together with the itemized bills, should be submitted to: