Subscriber Claim Form

Read instructions on reverse side.

Anthem

— IMPORTANT —

Please read and follow the instructions located on the front and back of this form. You are required to complete all unshaded areas of the form by printing clearly with a non-erasable ink pen. **This form will be returned to you if you do not provide the required information and attach an itemized bill from a hospital, doctor or supplier to the back of this form.**

1. PATIENT'S NAME (Last) (First) (M.I.)

2. PATIENT'S DATE OF BIRTH MONTH DAY YEAR

3. SUBSCRIBER'S CERTIFICATE NUMBER (INCLUDE ALPHA PREFIX)
PREFIX

4. PATIENT'S RELATIONSHIP TO SUBSCRIBER
SELF ☐ 1. SPOUSE ☐ 2. CHILD ☐ 3. OTHER ☐ 4.
SAME LAST NAME DEPENDENT

5. PATIENT'S SEX
MALE ☐ FEMALE ☐

6. SUBSCRIBER'S GROUP NUMBER
☐ CHECK IF NATIONAL ACCOUNT

7. SUBSCRIBER'S NAME (Last) (First) (M.I.)

8. WAS CONDITION RELATED TO:
A. PATIENT'S EMPLOYMENT? ☐ YES ☐ NO
B. ACCIDENT? ☐ YES ☐ NO

9. DATE ACCIDENT OR INJURY OCCURRED
MO. DAY YR.

10. SUBSCRIBER'S ADDRESS
STREET _____
CITY _____ STATE _____ ZIP _____
☐ NEW ADDRESS

11. IS THE PATIENT COVERED UNDER ANY OTHER HEALTH INSURANCE POLICY?
(If yes, indicate name of company and identification number)
☐ YES ☐ NO COMPANY NAME _____
IDENTIFICATION NUMBER _____

12. BILLING HOSPITAL, DOCTOR, SUPPLIER
NAME _____
STREET _____
CITY _____ STATE _____ ZIP _____

14. NAME(S) OF ILLNESSES OR INJURIES FOR WHICH THE PATIENT WAS TREATED
1.
2.
3.
4.

DIAGNOSIS CODE

BILLING PROVIDER I.D.

EIN/SSN I.D.

PAY CODE

13. REFERRING DOCTOR (DOCTOR WHO REFERRED PATIENT FOR TREATMENT)
NAME _____
STREET _____
CITY _____ STATE _____ ZIP _____

REFERRING PROVIDER I.D.

TYPE OF BILL

DO NOT WRITE IN SHADED AREA

15. DATE OF SERVICE (Mo./Day/Yr.) FROM TO	16.* PLACE OF SERVICE	REVENUE CODE	PROCEDURE CODE	17. DESCRIPTION OF SERVICE	DIAGNOSIS CODE	18. CHARGES	UNITS	ATTENDING PHYSICIAN I.D.

TOTAL SERVICES | TOTAL CHARGE | TOP 1 | 1

*** EXPLANATION OF BLOCK 16:** PLEASE INDICATE ONE OF THE FOLLOWING CODES TO IDENTIFY WHERE EACH SERVICE WAS PROVIDED.

DOCTOR'S OFFICE 1
PATIENT'S HOME 2
HOSPITAL/INPATIENT (BED PATIENT) 3
NURSING HOME (SKILLED NURSING FACILITY) 4
HOSPITAL/OUTPATIENT (EMERGENCY ROOM) 5
INDEPENDENT LAB 6
HOME HEALTH AGENCY 7
AMBULANCE 8
DURABLE MEDICAL EQUIP. SUPPLIER 9
PHARMACY (M & S SUPPLIES/DME) . . . . . .P

19. ATTENDING DOCTOR (DOCTOR WHO TREATED PATIENT)
NAME _____
STREET _____
CITY _____ STATE _____ ZIP _____

20. I AUTHORIZE THE RELEASE TO ANTHEM BLUE CROSS AND BLUE SHIELD OF ANY INFORMATION NECESSARY TO PROCESS THIS CLAIM.

SIGNATURE OF SUBSCRIBER

21. DATE FORM COMPLETED

THE PERSON SIGNING THIS FORM IS ADVISED THAT THE WILLFUL ENTRY OF FALSE OR FRAUDULENT INFORMATION RENDERS YOU LIABLE TO PROSECUTION.

3105 Rev. (8/04)

SUBMISSION INSTRUCTIONS

- Place itemized bill, receipt or Explanation of Benefits behind the completed Subscriber Claim Form. Send the completed Subscriber Claim Form and itemized bill, receipt or Explanation of Benefits to:

  Anthem Blue Cross and Blue Shield
  PO Box 533
  North Haven, CT 06473-0533

- This form is to be completed by the subscriber; accompanied by a copy of a hospital's UB-92 billing form (when hospital is outside of New Hampshire), or a doctor's or supplier's itemized bill or receipt, or an Explanation of Benefits from another health insurance plan or Medicare, and submitted to Anthem Blue Cross and Blue Shield for benefit consideration.
- Submit a completed Subscriber Claim Form for each patient with an itemized bill, receipt or Explanation of Benefits for that patient, as soon as a provider's (one provider per claim form) itemized bill, receipt or an Explanation of Benefits is received.
- **EACH ITEMIZED BILL OR RECEIPT MUST CONTAIN:**

  —Name and address of hospital, doctor or supplier
  —When the itemized bill or receipt lists the names of several doctors or suppliers, please circle the name and address of the individual who treated the patient.
  —Patient's name
  —Date of each service
  —Place of each service
  —Complete description of each service
  —Charge for each service
  —Additional information required for:
    —Ambulance bills—Destination transported and mileage accrued
    —Durable Medical Equipment bills—Purchase price whether rented or purchased. If rented, rental period, start and end date
    —Prescription drugs—Submit on Prescription Drug Claim Form
    —Private duty nurse—Degree of nurse and hours worked (day and night)

- **PLEASE RETAIN COPIES OF ITEMIZED BILLS, RECEIPTS OR EXPLANATION OF BENEFITS FOR YOUR RECORDS AS THEY WILL NOT BE RETURNED TO YOU.**
- **DATA BLOCKS REQUIRING SPECIAL ATTENTION**

  BLOCK 3 —You must include the 3-letter prefix, which is part of your Subscriber Certificate Number as found on your ID card.
  BLOCK 4 —Check OTHER when a dependent child's last name differs from the subscriber's last name
  BLOCK 6 —Check NATIONAL ACCOUNT when the subscriber's ID card indicates National Account.
  BLOCK 10 —Check NEW ADDRESS when subscriber's address is different from previous submission.
  BLOCK 14 —LIST THE ILLNESS OR INJURIES FOR WHICH THE PATIENT RECEIVED THE SERVICE(S) LISTED ON THE ITEMIZED BILL, RECEIPT OR EXPLANATION OF BENEFITS.
  BLOCK 17 —When applicable indicate the following information obtained from the itemized bill or the doctor's office:
    —Length of time for anesthesia, intensive care or psychotherapy sessions
    —Length, location and number of lacerations
    —Location and number of lesions

- **QUESTIONS OR PROBLEMS**

  If you have any questions regarding the completion of this form, or require additional Subscriber Claim Forms, please contact the Customer Service Center at the address listed below or call the Customer Service Number listed on the back of your Identification Card.

ADMINISTRATIVE OFFICE

Anthem Blue Cross and Blue Shield
PO Box 660
North Haven, CT 06473-0660

EXPRESS SCRIPTS®
Charting the Future of Pharmacy

PRESCRIPTION DRUG CLAIM FORM

DIV

Cardholder's Name (Last, First, MI)	Date of Birth	Gender (circle) M F	Cardholder ID Number

❑ Check if new address

Address Street_____

City/State_____ Zip Code_____ Daytime Telephone (_____)_____

Employer	Insurance Carrier	Group Number

PLEASE SIGN AND DATE HERE: I certify that all information provided is correct and that the prescription(s) submitted are for me or members of my family who are eligible. The patient(s) listed below has (have) received the medication, and I authorize release of all information contained on this claim to Express Scripts, Inc. and my Plan Sponsor. Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Cardholder's Signature **Date**

Patient Information (please list information for each patient submitting claims)

1	Patient's Name	Relationship to Cardholder?(circle) Self, spouse, dependant	Gender (circle) M F	Date of Birth	Total number of receipts attached:
Pharmacy Name and Address:			Physician Name (name of prescribing Doctor) and DEA#:		

2	Patient's Name	Relationship to Cardholder?(circle) Self, spouse, dependant	Gender (circle) M F	Date of Birth	Total number of receipts attached:
Pharmacy Name and Address:			Physician Name (name of prescribing Doctor) and DEA#:		

3	Patient's Name	Relationship to Cardholder?(circle) Self, spouse, dependant	Gender (circle) M F	Date of Birth	Total number of receipts attached:
Pharmacy Name and Address			Physician Name (name of prescribing Doctor) and DEA#:		

Is claim for **DIABETIC SUPPLY**? ☐ yes ☐ no. If **Yes**, Please provide receipt stating: Pharmacy Name/Address • Date Filled • Type of Insulin and/or Type of supply • Quantity • Days Supply • Price •Patient's Name. Cash register receipts are acceptable but **Pharmacist Signature** is required if any information is handwritten. ****Ask your pharmacist how you can purchase diabetic supplies with your prescription card****

Does the patient reside in an **assisted living facility**? ☐ yes ☐no Is this claim for **allergy serum**? ☐ yes ☐no

Does the patient have primary prescription drug coverage through another insurance carrier? ☐yes ☐no

Did the patient submit this claim to the other carrier? ☐ yes ☐no *If yes, please attach an explanation of benefits from your primary carrier.*

Prescription Information

➔ **IMPORTANT**← **All prescription claims must have prescription receipts/labels which include:**

• Pharmacy Name/Address • Date Filled • Drug Name, Strength and NDC • Rx Number • Quantity • Days Supply • Price • Patient's Name

Claims received missing any of the above information may be returned or payment may be denied or delayed

☒ **Please tape receipts to separate piece of paper.**

☒ **Patient history print outs from the pharmacy are also acceptable but MUST be signed by the Pharmacist.**

☒ **CASH REGISTER RECEIPTS ARE NOT ACCEPTABLE FOR ANY PRESCRIPTIONS.**
(With the exception of diabetic supplies)

REASON FOR CLAIM SUBMISSION OR SPECIAL NOTES:

ESI USE ONLY

PLEASE READ THE FOLLOWING INSTRUCTIONS CAREFULLY AND COMPLETE FORM ON REVERSE SIDE.

Cardholder's Information (The Cardholder is the insured member whose employer provides this benefit.)

1. Print Cardholder's name (last, first, middle initial).
2. Print Cardholder's date of birth.
3. Circle the correct letter to indicate if Cardholder is male or female.
4. Print Cardholder's ID number (found on prescription drug or Health Insurance card).
5. Print Cardholder's mailing address and telephone numbers. Check box if this is a new address.
6. Indicate Cardholder's employer, insurance carrier and group number (refer to drug card).

IMPORTANT: CLAIM FORM MUST BE SIGNED.
UNSIGNED CLAIM FORMS CANNOT BE PROCESSED AND WILL BE RETURNED.

Patient Information (Complete a section for <u>each</u> family member who is submitting prescriptions.)

1. Print Patient's name.
2. Identify relationship to cardholder, gender, date of birth, and number of prescriptions submitted for each patient.
3. Print Pharmacy name and address and the prescribing Doctor and DEA number used by each patient.

Specific Claim Information

1. Answer each question by checking correct box. Use the space provided for special notes if necessary.

Prescription Information Each submission must include:
Prescription receipts/labels **<u>or</u>** a patient history printout from your pharmacy, **signed** by the dispensing pharmacist, which include all information listed below:

- Pharmacy name and address
- Date filled
- Drug name, strength and NDC number
- Rx Number
- Quantity
- Days Supply
- Price
- Patient's name

(Please note that Claims received missing any of the above information may be returned or payment may be denied.)

It is preferable to have receipts unattached or taped to a separate piece of paper. *Please* DO NOT staple or glue.

Reason for claim submission or special notes
This section can be used for special notes or comments.

Questions? Call Express Scripts Customer Service Department at 1-800-451-6245

Please return this claim to: **Express Scripts, Inc.**
P.O. Box 66583
St. Louis, MO 63166-6583
ATTN: STD ACCTS