3 HEALTH INSURANCE CLAIM FORM

Send Completed Claim Form To:
Blue Cross and Blue Shield of Illinois
P.O. Box 805107
CHICAGO, IL 60680-4112

PLEASE PRINT OR TYPE CLEARLY

NOTICE TO ALL PARTIES COMPLETING THIS FORM: It is fraudulent to fill out this form with information you know to be false or to omit important facts. Criminal and/or civil penalties can result from such acts.

ID NUMBER -- Copy this from your Blue Cross and Blue Shield Identification Card.

GROUP NUMBER:	IDENTIFICATION NUMBER:

PATIENT INFORMATION -- A separate claim form must be completed for each family member.

PATIENT'S FULL LEGAL NAME (Last, First, Middle Initial)	SEX: ❑ Male ❑ Female	SOCIAL SECURITY NUMBER (optional): ___-___-____	DATE OF BIRTH Month / Day / Year

PATIENT IS: ❑ Member ❑ Spouse ❑ Child OTHER, please explain relationship:

IF CLAIM IS FOR CHILD 19 OR OLDER—IS CHILD: A full-time student? ❑ Yes ❑ No Handicapped? ❑ Yes ❑ No

PAYEE:

❑ MAKE PAYMENT TO THE **PROVIDER** (hospital, doctor etc.), OR

❑ MAKE PAYMENT TO **MEMBER**, the provider has been paid

MEMBER INFORMATION

MEMBER (POLICY HOLDER) NAME: (As shown on your Blue Cross and Blue Shield ID Card)	SOCIAL SECURITY NUMBER (optional): ___-___-____	DATE OF BIRTH Month / Day / Year

CURRENT ADDRESS:	HOME PHONE: (___)___-____
IF COVERAGE IS THRU YOUR EMPLOYER, PROVIDE GROUP (EMPLOYER) NAME:	WORK PHONE: (___)___-____

CLAIM INFORMATION

IS CLAIM FOR AN ACCIDENTAL INJURY? ❑ Yes ❑ No	IS THIS A WORKERS COMPENSATION CLAIM? ❑ Yes ❑ No	DATE OF ACCIDENT:

BRIEFLY DESCRIBE INJURY:

COMPLETE BELOW IF NON-ACCIDENTAL INJURY OR ILLNESS

DATE FIRST TREATED:	BRIEFLY DESCRIBE THE CONDITION(S) FOR WHICH THE PATIENT RECEIVED THESE SERVICES: (You can usually copy the diagnosis or description of service from the provider bill.)

OTHER INSURANCE INFORMATION

Are there any OTHER medical benefits available to you, your spouse, or your dependents from OTHER Group Insurance, including OTHER Blue Cross and Blue Shield policies, OTHER Employer, Labor or Professional Organizations, School, etc.?
❑ Yes (provide below) ❑ No

POLICY HOLDER NAME:	SOCIAL SECURITY NUMBER (optional): ___-___-____

POLICY HOLDER IS: ❑ Member ❑ Spouse ❑ Child ❑ OTHER, please explain relationship:

INSURANCE CARRIER NAME:	POLICY NUMBER:	EFFECTIVE DATE:

ADDRESS:	PHONE NUMBER: (___)___-____

RELEASE OF INFORMATION: I certify that the above information is correct and that the bills attached were incurred by the patient listed above. I understand that Blue Cross and Blue Shield's use or disclosure of individually identifiable health information, whether furnished by me or obtained from other sources such as medical providers, shall be in accordance with the federal privacy regulations under HIPAA (Health Insurance Portability and Accountability Act of 1996).

Sign Here _____ **Date** _____

Signature of Member

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