



**BlueCross BlueShield  
of Florida**

An Independent Licensee of the  
Blue Cross and Blue Shield Association

**MEDICAL CLAIM FORM**

Claims Department

P.O. Box 3355

Pittsburgh, PA 15230-3355

**TO BE COMPLETED BY EMPLOYEE**

**EMPLOYEE INFORMATION:**

1. EMPLOYEE'S NAME (LAST)			(FIRST)			(MIDDLE INITIAL)			
2. EMPLOYEE'S ADDRESS (STREET)			(CITY)			(STATE)		(ZIP CODE)	
3. EMPLOYEE'S IDENTIFICATION NUMBER					4. EMPLOYEE'S PHONE NUMBER ( ) AREA CODE				

**PATIENT INFORMATION:**

5. PATIENT'S NAME (LAST)			(FIRST)			(MIDDLE INITIAL)			
6. PATIENT'S BIRTH DATE		7. PATIENT'S SEX		8. PATIENT'S RELATIONSHIP TO MEMBER			9. DIAGNOSIS OR NATURE OF ILLNESS		
MONTH	DAY	YEAR	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	<input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD					
10. WAS AN ACCIDENT INVOLVED? <input type="checkbox"/> YES <input type="checkbox"/> NO					WHERE: <input type="checkbox"/> AUTO <input type="checkbox"/> WORK <input type="checkbox"/> OTHER: ( ENCLOSE A BRIEF DESCRIPTION OF HOW AND WHERE ACCIDENT OCCURRED )				
IF YES WHEN?	MONTH	DAY	YEAR						

**OTHER COVERAGE:**

11. IS THE PATIENT COVERED BY ANY OTHER INSURANCE PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO									
IF YES	NAME OF INSURANCE COMPANY						POLICY NUMBER		
	ADDRESS OF INSURANCE COMPANY								
12. IS THE PATIENT ELIGIBLE FOR MEDICARE? <input type="checkbox"/> YES <input type="checkbox"/> NO									
IF YES	MEDICARE PART A EFFECTIVE DATE	MONTH	DAY	YEAR	MEDICARE PART B EFFECTIVE DATE	MONTH	DAY	YEAR	
13. IS THE PATIENT A FULL-TIME STUDENT OVER 19 YEARS OLD? <input type="checkbox"/> YES <input type="checkbox"/> NO									
IF YES	SCHOOL NAME						DATES OF CURRENT TERM		
	SCHOOL ADDRESS						EXPECTED DATE OF GRADUATION		

**ASSIGNMENT OF BENEFITS:**

ATTENTION EMPLOYEE:

14. IF YOU DO NOT WISH TO SIGN, PAYMENT WILL BE SENT DIRECTLY TO YOU.  
PLEASE NOTE: A SEPARATE CLAIM FORM IS NEEDED FOR EACH PROVIDER TO WHOM YOU ARE ASSIGNING BENEFITS.  
I HEREBY AUTHORIZE PAYMENT TO THE PROVIDER OF SURGICAL AND/OR MEDICAL BENEFITS, IF ANY.

EMPLOYEE'S SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

**NOTE: PLEASE BE SURE THAT THE PROVIDER'S FEDERAL TAX CERTIFICATION NUMBER IS PRINTED ON THE ITEMIZED BILL. IF TAX I.D. NUMBER IS NOT PROVIDED, PAYMENT MAY BE SENT TO THE EMPLOYEE.**

**EMPLOYEE'S SIGNATURE:**

15. 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. The signer agrees that any personally identifiable health information about the signer or signer's enrolled dependents is protected by the Health Insurance Portability and Accountability Act of 1996 and other privacy laws. In accordance with those laws, The Health Plan may use and disclose Protected Health Information for treatment, payment and health care operations as described in its Notice of Privacy Practices..

X EMPLOYEE'S SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

# TO BE COMPLETED BY PHYSICIAN OR OTHER PROVIDER OF SERVICE

## PATIENT & INSURED (MEMBER) INFORMATION

READ INSTRUCTIONS BEFORE COMPLETING OR SIGNING THIS FORM.

1. PATIENT'S NAME (First name, middle initial, last name)	2. PATIENT'S DATE OF BIRTH	3. MEMBER'S NAME (First name, middle initial, last name)
4. PATIENT'S ADDRESS (Street, city, state, zip code)	5. PATIENT'S SEX MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>	6. MEMBER'S I.D. (Include any letters)
	7. PATIENT'S RELATIONSHIP TO MEMBER SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER <input type="checkbox"/>	8. MEMBER'S GROUP NUMBER (Or Group Name)
TELEPHONE NUMBER	9. OTHER HEALTH INSURANCE COVERAGE - Enter Name of Policyholder and Plan Name and Address and Policy or Medical Assistance Number	11. MEMBER'S ADDRESS (Street, city, state, zip code)
10. WAS CONDITION RELATED TO A. PATIENT'S EMPLOYMENT YES <input type="checkbox"/> NO <input type="checkbox"/> B. AN ACCIDENT AUTO <input type="checkbox"/> OTHER <input type="checkbox"/>		

## PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF	ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)	15. DATE FIRST CONSULTED YOU FOR THIS CONDITION	16. HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS? YES <input type="checkbox"/> NO <input type="checkbox"/>	16A. IF AN EMERGENCY CHECK HERE <input type="checkbox"/>
17. DATE PATIENT ABLE TO RETURN TO WORK	18. DATES OF TOTAL DISABILITY FROM _____ THROUGH _____		DATES OF PARTIAL DISABILITY FROM _____ THROUGH _____	
19. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE (e.g., public health agency)			20. FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES ADMITTED _____ DISCHARGED _____	
21. NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED (If other than home or office)			22. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE? YES <input type="checkbox"/> NO <input type="checkbox"/> CHARGES	

23A. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY – RELATE DIAGNOSIS TO PROCEDURE IN COLUMN E BY REFERENCE NUMBER 1, 2, 3, ETC. OR DX CODE

1	
2	
3	
4	

24.	A. DATE OF SERVICE		B. PLACE OF SERVICE	C. T O S	D. FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN (EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)	E. DIAGNOSIS CODE	F. CHARGES			G. DAYS OR UNITS	H. LEAVE BLANK
	FROM	TO									

25. SIGNATURE OF PHYSICIAN OR SUPPLIER <i>(I certify that the statements on the reverse apply to this bill and are made a part hereof)</i>	26. HAS FEE BEEN PAID? YES <input type="checkbox"/> NO <input type="checkbox"/>	27. TOTAL CHARGE	28. AMOUNT PAID	29. BALANCE DUE
SIGNED _____ DATE _____	30. YOUR SOCIAL SECURITY NO./ TAX I.D. NO.	31. PHYSICIAN'S OR ACCOUNT'S NAME, ADDRESS, ZIP CODE & PROVIDER NO.		
32. YOUR PATIENT'S ACCOUNT NO.	33. YOUR EMPLOYER I.D. NO.	34. YOUR TELEPHONE NO.		

**PLACE OF SERVICE CODES**

- |                                |                                      |  |
|--------------------------------|--------------------------------------|--|
| 1 — (IH) — Inpatient Hospital  | 6 — — Night Care Facility — (PSY)    | A — (IL) — Independent Laboratory          |
| 2 — (OH) — Outpatient Hospital | 7 — (NH) — Nursing Home              | B — — Other Medical Surgical Facility      |
| 3 — (O) — Doctor's Office      | 8 — (SNF) — Skilled Nursing Facility | C — (RTC) — Residential Treatment Center   |
| 4 — (H) — Patient's Home       | 9 — — Ambulance                      | D — (STF) — Specialized Treatment Facility |
| 5 — — Day Care Facility (PSY)  | 0 — (OL) — Other Locations           |  |

For Assignment of Benefits to provider, patient must sign at #14 on the front of this claim form.