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: (Include 3-digit alpha prefix)

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: __ __ __/__ __/__ __ __ __ | 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: __ __ __/__ __/__ __ __ __ | DATE OF BIRTH Month Day Year

CURRENT ADDRESS: | HOME PHONE: (__ __ __)__ __ __-__ __ __ __

IF COVERAGE IS THRU YOUR EMPLOYER, PROVIDE | GROUP (EMPLOYER) NAME: | WORK PHONE: (__ __ __)__ __ __-__ __ __ __

CLAIM INFORMATION

COMPLETE BELOW IF [illegible] 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.)

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

BRIEFLY DESCRIBE INJURY:

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: __ __ __/__ __/__ __ __ __

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 authorize any medical professional, hospital, medical or medically related facility, pharmacy, government agency, insurance company, or other person or firm to provide Blue Cross and Blue Shield information, including copies or records, concerning advice, care or treatment provided the patient above including, without limitation, information relating to mental illness, use of drugs or alcohol, upon presentation of the original copy of this signed authorization. I understand that such information will be used by Blue Cross and Blue Shield for the purpose of evaluating a claim for insurance benefits for services provided to the patient named above. I understand that I or any authorized representative will receive a copy of this authorization upon request. The authorization is valid from the date signed for the duration of the claim.

Sign Here _____ **Date** _____

01103.1206 **Signature of Member**