



P.O. Box 805107 • Chicago, Illinois 60680-4112

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

Please print or type.

1 Insured/Subscriber Name (Last, First, Middle Initial) Mailing Address City and State ZIP Code Insured Employed? Date of Retirement: Month Day Year 2 Group Number Insured/Subscriber Identification Number (from ID card) Patient's Full Name (Last, First, Middle) Patient's Sex Patient's Date of Birth Month Day Year Patient's Relationship to Insured

3 Type of treatment received: 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: Illness - Date of first symptom: Pregnancy - Date of conception: Preventive - Date of service: Month Day Year

4 Describe: Diagnosis, symptoms of illness or injury or explain preventive or routine care received.

5 Was illness or injury work connected? Name and address of employer

6 If injury, was a motor vehicle involved?

7 Is patient covered under any other health benefits plan (besides Medicaid, Medicare or CHAMPUS)? Insurance Co. Address Employer Insured name Policy # Effective date of coverage Sex of Insured Date of birth of insured Relationship to patient

8 Medicare - Is the patient: a) Entitled to benefits under Medicare insurance (Part A)? b) Entitled to benefits under Medicare insurance (Part B)? c) Entitled to benefits under Medicare due to a disability? Patient's Medicare Identification Number. (From Medicare ID card)

9 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 Illinois, upon request, any medical information which the Plans in their judgment deem necessary to the adjudication of this claim. Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Signature of Insured Date Daytime telephone number

10 Total amount for ALL covered services and supplies received. \$ Itemized Bill(s) for covered services and supplies must be attached. (See Instructions on reverse side.)



INSTRUCTIONS

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

Please complete every item on claim form.

Table with 9 rows and 2 columns. Row 1: Insured/subscriber's name, address and employment status. Row 2: Patient information. Row 3: Type of treatment received. Row 4: Diagnosis or symptoms of illness or injury. Row 5: If illness or injury is in any way work-related. Row 6: If motor vehicle injury. Row 7: Other insurance. Row 8: Medicare information. Row 9: Insured's signature, date and daytime telephone number.

Example of Itemized Bill — Please remember to attach the original bill(s) to the claim form and make a copy for your records. Itemized bills cannot be returned.

Diagram showing an example of an itemized bill with callouts. Callouts include: Name of the person or organization providing the services or supplies; Name of the patient receiving the services or supplies; NOTE: Bills for Private Duty Nursing Service must show the professional status of the nurse; Date each service or supply was provided; Description of the services or supplies provided; Charge for each service or supply; If you are submitting itemized bills for a variety of services please use a separate claim form for each different type of treatment; Please cross out those charges which were included on a previous claim; FOR OTHER THAN PRESCRIPTION DRUG CARD HOLDERS: Bills for Prescription Drugs must show the name of each drug, the prescription number, the quantity dispensed, the date of purchase, and the amount charged for each drug.

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

Blue Cross and Blue Shield of Illinois
P.O. Box 805107
Chicago, Illinois 60680-4112