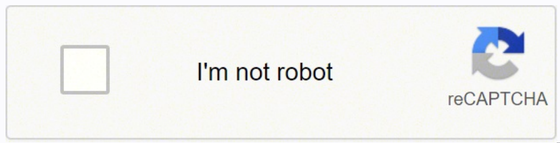

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Bcbs of illinois claim forms

State and Public School Employees'
Health Insurance Plans

MEDICAL CLAIM FORM

*** * * IMPORTANT: PLEASE READ THE INSTRUCTIONS ON THE BACK OF THIS FORM * * ***
*** * Your Physician does not need to sign this form * ***
Please complete and sign a separate form for each patient

PATIENT INFORMATION

1. Patient's Name (No nicknames please)
First MI Last

2. Name as Shown on I.D. Card
First MI Last

3. Patient's Date of Birth
____ / ____ / ____
Month Day Year

4. Identification Number as Shown on I.D. Card

5. Patient's Sex
☐ Male ☐ Female

6. Patient's Relationship to Employee
☐ Self ☐ Child ☐ Spouse ☐ Other

7. Current Mailing Address
Street City State Zip

Current Telephone Numbers: Home ____ Office ____
Area Code (optional) Area Code

Payments and Explanation of Benefits will be sent to the most current address listed in our files. If your address changes, you must contact our Membership Services Department.

OTHER HEALTH INSURANCE INFORMATION

8. Is patient covered under any other health insurance plan? ☐ Yes ☐ No
If yes, complete the following: Name of Policyholder
Last First Middle
Name of Employer (if group coverage)
Name and Address of Insuring Company
Name
Street
Policy # City State Zip

9. Is patient covered under Medicare Part A (hospital) or Medicare Part B (medical):
Medicare Part A ☐ Yes ☐ No Effective Date ____ / ____ / ____
Month Day Year
Medicare Part B ☐ Yes ☐ No Effective Date ____ / ____ / ____
Month Day Year
Medicare Identification #

Is employee still actively employed?
☐ Yes ☐ No
If no, please enter effective date of retirement/ termination. ____ / ____ / ____
Month Day Year

CONDITION AND TREATMENT

10. Was condition related to:
Employment ☐ Auto Accident ☐ Other Accident/Injury ☐ Illness ☐

11. If Accident/Injury, give date.
____ / ____ / ____
Month Day Year

12. Describe the nature of accident or illness and list symptoms.

AUTHORIZATION

I certify that the information I have given is accurate to the best of my knowledge and that I am claiming benefits only for the charges incurred by the patient identified above. I authorize the release of any medical information necessary to process this claim.

Signature Date

BCBS 13007 11/97 – over –

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3 **HEALTH INSURANCE CLAIM FORM**
Send Completed Claim Form To:
Blue Cross and Blue Shield of Illinois

CHICAGO, IL 60680-4112

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.

PLEASE PRINT OR TYPE CLEARLY

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) Month Day Year SOCIAL SECURITY NUMBER (optional) DATE OF BIRTH

CURRENT ADDRESS/HOME PHONE: ( ) -

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

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:

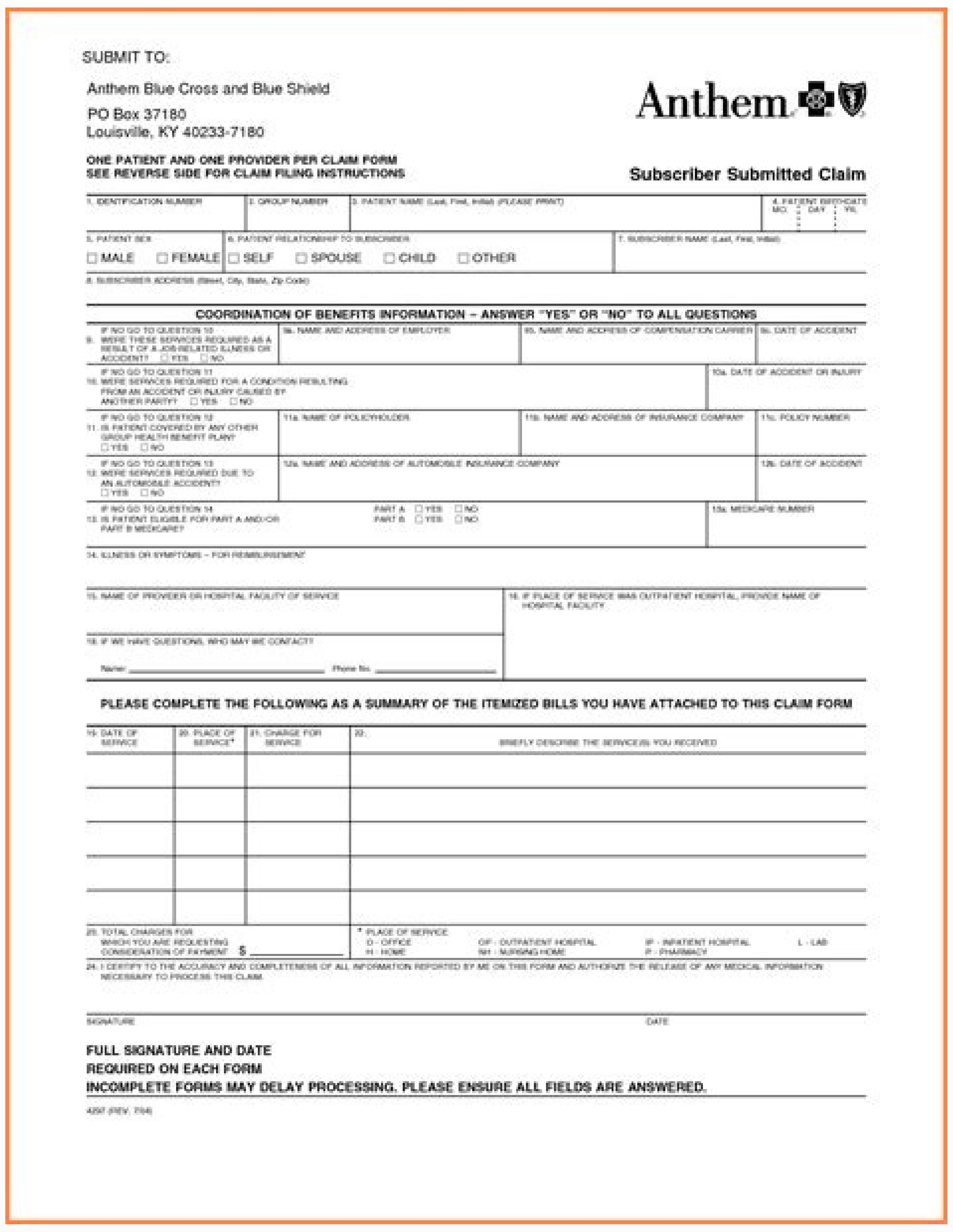
INSURANCE CARRIER NAME/POLICY NUMBER/EFFECTIVE DATE:

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

20479.0607



SUBMIT TO:

Anthem Blue Cross and Blue Shield
PO Box 37180
Louisville, KY 40233-7180

Anthem

ONE PATIENT AND ONE PROVIDER PER CLAIM FORM
SEE REVERSE SIDE FOR CLAIM FILING INSTRUCTIONS

Subscriber Submitted Claim

1. IDENTIFICATION NUMBER | 2. GROUP NUMBER | 3. PATIENT NAME (Last, First, Initial) (PLEASE PRINT) | 4. PATIENT BIRTHDATE MO. DAY YR.

5. PATIENT SEX ☐ MALE ☐ FEMALE | 6. PATIENT RELATIONSHIP TO SUBSCRIBER ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER | 7. SUBSCRIBER NAME (Last, First, Initial)

8. SUBSCRIBER ADDRESS (Street, City, State, Zip Code)

COORDINATION OF BENEFITS INFORMATION – ANSWER "YES" OR "NO" TO ALL QUESTIONS

9. IF NO GO TO QUESTION 10. WERE THESE SERVICES REQUIRED AS A RESULT OF A JOB-RELATED ILLNESS OR ACCIDENT? ☐ YES ☐ NO | 9a. NAME AND ADDRESS OF EMPLOYER | 9b. NAME AND ADDRESS OF COMPENSATION CARRIER | 9c. DATE OF ACCIDENT

10. IF NO GO TO QUESTION 11. WERE SERVICES REQUIRED FOR A CONDITION RESULTING FROM AN ACCIDENT OR INJURY CAUSED BY ANOTHER PARTY? ☐ YES ☐ NO | 10a. DATE OF ACCIDENT OR INJURY

11. IF NO GO TO QUESTION 12. IS PATIENT COVERED BY ANY OTHER GROUP HEALTH BENEFIT PLAN? ☐ YES ☐ NO | 11a. NAME OF POLICYHOLDER | 11b. NAME AND ADDRESS OF INSURANCE COMPANY | 11c. POLICY NUMBER

12. IF NO GO TO QUESTION 13. WERE SERVICES REQUIRED DUE TO AN AUTOMOBILE ACCIDENT? ☐ YES ☐ NO | 12a. NAME AND ADDRESS OF AUTOMOBILE INSURANCE COMPANY | 12b. DATE OF ACCIDENT

13. IF NO GO TO QUESTION 14. IS PATIENT ELIGIBLE FOR PART A AND/OR PART B MEDICARE? PART A ☐ YES ☐ NO PART B ☐ YES ☐ NO | 13a. MEDICARE NUMBER

14. ILLNESS OR SYMPTOMS – FOR REIMBURSEMENT

15. NAME OF PROVIDER OR HOSPITAL FACILITY OF SERVICE | 16. IF PLACE OF SERVICE WAS OUTPATIENT HOSPITAL, PROVIDE NAME OF HOSPITAL FACILITY

18. IF WE HAVE QUESTIONS, WHO MAY WE CONTACT?
Name: ________ Phone No. ________

PLEASE COMPLETE THE FOLLOWING AS A SUMMARY OF THE ITEMIZED BILLS YOU HAVE ATTACHED TO THIS CLAIM FORM

19. DATE OF SERVICE	20. PLACE OF SERVICE*	21. CHARGE FOR SERVICE	22. BRIEFLY DESCRIBE THE SERVICE(S) YOU RECEIVED

23. TOTAL CHARGES FOR WHICH YOU ARE REQUESTING CONSIDERATION OF PAYMENT $ ________

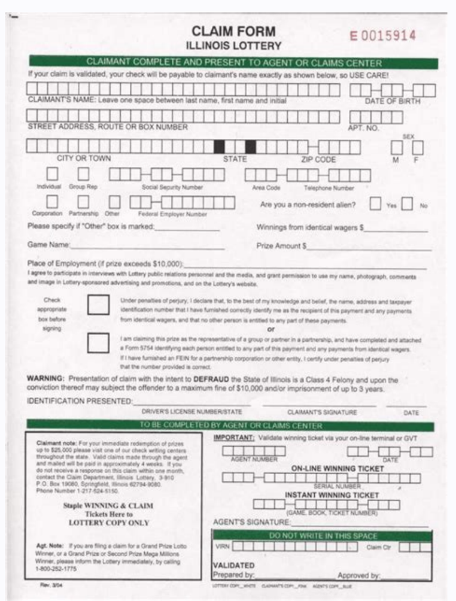
* PLACE OF SERVICE: O - OFFICE; H - HOME; OP - OUTPATIENT HOSPITAL; NH - NURSING HOME; IP - INPATIENT HOSPITAL; P - PHARMACY; L - LAB

24. I CERTIFY TO THE ACCURACY AND COMPLETENESS OF ALL INFORMATION REPORTED BY ME ON THIS FORM AND AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM.

SIGNATURE DATE

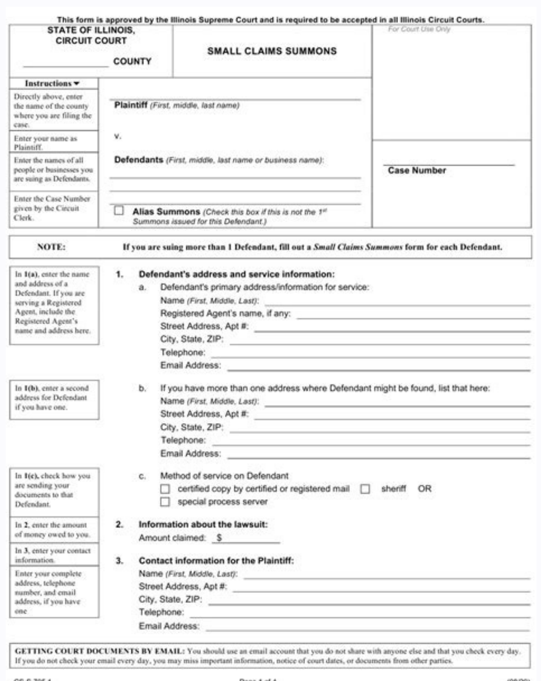
FULL SIGNATURE AND DATE
REQUIRED ON EACH FORM
INCOMPLETE FORMS MAY DELAY PROCESSING. PLEASE ENSURE ALL FIELDS ARE ANSWERED.

4297 (REV. 7/04)



CLAIM FORM
ILLINOIS LOTTERY
E 0015914

CLAIMANT COMPLETE AND PRESENT TO AGENT OR CLAIMS CENTER



This form is approved by the Illinois Supreme Court and is required to be accepted in all Illinois Circuit Courts.

STATE OF ILLINOIS,
CIRCUIT COURT
COUNTY

SMALL CLAIMS SUMMONS

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