Medical Claim Form

Anthem®

Section 1: Patient information

Last name | First name | M.I.

Does the patient have other health insurance coverage? ☐ ☐

Relation to subscriber ☐ ☐ ☐ ☐

Sex ☐ ☐

Date of birth (MM/DD/YYYY)

Name of other health insurance company | Group no. | Employer name | Policy no.

Section 2: Subscriber information (on Anthem Blue Cross ID card)

Identification no. (include prefix) | Group no.

Last name | First name | M.I.

Street address (please include apt. no.) | City | State | ZIP code

Home phone no. | Work phone no. | Date of birth (MM/DD/YYYY)

Section 3: Medical information

Health care services: [illegible] .) Attach itemized bill or photocopy. [illegible]

☐ ☐ ☐ ☐

How to use this form

Section 1: Patient information

Section 2: Subscriber information (on Anthem Blue Cross ID card)

Section 3: Medical information

Health care services: .) Attach itemized bill or photocopy.