Medical Claim Form



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.		/er name	Policy no.
Section 2: Subscriber information (on Anthem B	Blue Cross ID card)			
Identification no. (include prefix)	our di our di	Group no.		
Last name		First name		M.I.
Street address (please include apt. no.)		City		State ZIP code
Home phone no.	Work p	hone no.		Date of birth (MM/DD/YYYY
Section 3: Medical information	l			
Health care services: - ,	11/2/ 1/2/	11- K""	, "'/ <u>] /</u> -' , - ₁	10-1 HIPPAN 1 1 1-1
Marian, Cira , k, k, ek, r	1 11111 5 5 5	الله ، , , د .) Attach item	ized bill or photoco	py.1/12/12/11 == == 1/1 =/ 1/1
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How to use this form

Section 1: Patient information

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

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Section 3: Medical information

Health care services; a read regard r