# 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) |
|---|---|---|---|
| ☐ Yes ☐ No | ☐ Self ☐ Spouse ☐ Child ☐ Other | ☐ M ☐ F | |

| 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]

☐ [illegible] ☐ [illegible] ☐ [illegible] ☐ [illegible]

| | | | | |
|---|---|---|---|---|
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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.