



An Independent Licensee of the Blue Cross and Blue Shield Association.

**FILL OUT A SEPARATE FORM FOR EACH PATIENT.**

Use this form to file a claim for any eligible medical expenses when your physician or other provider does not file a claim. Please **print** clearly with black ink or **type**.

<b>1. Patient's Name</b> (only one Patient per form)																						
_____		_____																				
Last	First	Middle Initial																				
<b>2. Contract Number as shown on your I.D. Card</b> (include any letters, if applicable)		<b>3. Group Number (as shown on I.D. Card) or Place of employment</b>																				
_____		_____																				
<b>4. Patient's Date of Birth</b>		<b>5. Patient's Sex</b> <input type="checkbox"/> Male <input type="checkbox"/> Female																				
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mm	dd							yyyy														
<b>6. Patient's Relationship to Contract Holder</b>																						
<input type="checkbox"/> Self <input type="checkbox"/> Child <input type="checkbox"/> Spouse <input type="checkbox"/> Other (explain) _____																						
<b>7. Contract Holder Information</b> (name as shown on your I.D. card)																						
_____		_____																				
Last	First	Middle Initial																				
Street _____		(    ) _____																				
City _____	State _____	Zip Code _____	Daytime telephone number and extension _____																			
<b>8. Is patient covered under any other group health insurance plan?</b> (including any other Blue Cross and Blue Shield coverage).																						
<input type="checkbox"/> YES <input type="checkbox"/> NO    If <b>yes</b> , complete the following:																						
<b>Name of Policy Holder</b> _____																						
Last		First																				
Middle Initial																						
<b>Name and Address of Insuring Company</b> _____			<b>I.D. Number</b> _____																			
<b>Is the patient entitled to Medicare benefits?</b>		<b>Policy Effective Date</b>																				
Part A <input type="checkbox"/> YES <input type="checkbox"/> NO    Part B <input type="checkbox"/> YES <input type="checkbox"/> NO		<table style="width:100%; border-collapse: collapse;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> <tr> <td style="text-align: center;">mm</td> <td style="text-align: center;">dd</td> <td colspan="6"></td> <td style="text-align: center;">yyyy</td> </tr> </table>												mm	dd							yyyy
mm	dd							yyyy														
<b>Medicare Number</b> _____																						
<b>9. Was condition related to:</b>																						
a. Patient's Employment <input type="checkbox"/> YES <input type="checkbox"/> NO		(If <b>yes</b> , give date of accident or onset of illness):																				
b. Auto Accident <input type="checkbox"/> YES <input type="checkbox"/> NO		_____																				
c. Other Accident/Injury <input type="checkbox"/> YES <input type="checkbox"/> NO		<table style="width:100%; border-collapse: collapse;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> <tr> <td style="text-align: center;">mm</td> <td style="text-align: center;">dd</td> <td colspan="6"></td> <td style="text-align: center;">yyyy</td> </tr> </table>												mm	dd							yyyy
mm	dd							yyyy														
<b>10. Diagnoses</b> (type of illness or injury)		<b>11. Ordering Physician</b>																				
_____		Phone: (    ) _____																				
_____		Last Name _____ First Name _____																				
_____		Address _____ City _____ State _____ ZIP _____																				

**INSTRUCTIONS:** Attach the original bill or statement from the physician or supplier and **keep a copy for your records. Make sure the bill contains all required information** (see back of form for required information). **Sign this form.**

I, the undersigned, furnished the above information to enable Blue Cross and Blue Shield of Alabama to consider this claim for payment, and I certify that such information is true and correct and that the expenses were incurred by the above named patient. **I understand that any payment will be made to me.**

Signature \_\_\_\_\_ Date \_\_\_\_\_

**SEE BACK OF CLAIM FORM FOR EASY CLAIM FILING INSTRUCTIONS**

# FILING YOUR CLAIM IS EASY

1. Fill out the Medical Expense Claim form (include all requested information).
2. Attach the bill (or clear copy of the bill) to this form.

## **Your bill should include the following information: (do not attach a balance forward bill)**

- Patient's full name.
- Date of treatment.
- A description of the treatment provided (i. e. office visit, x-ray, surgery etc.)
- A diagnosis (type of illness or injury).
- Charge for each treatment.
- Place of treatment (i.e. doctor's office, hospital, one day surgery clinic, etc.)
- Date of accident (if applicable).
- Any Medical Equipment and/or supplies purchased. (Supply the invoice and be sure to complete box 11, Ordering Physician, on the front of this form.)

**Note:** The above information is usually provided on an itemized bill from the provider.)

## **THIS INFORMATION IS NEEDED TO PROPERLY FILE PRESCRIPTION DRUG CLAIMS.**

**(NOTE: FOR FILING POINT-OF-SALE PRESCRIPTION DRUG CLAIMS, USE CLAIM FORM CL-94.)**

Attach the receipt or legible copy of receipt given by the pharmacist. The receipt should list the following information:

- The patient's name.
- The National Drug Code (NDC).
- The name of the prescription drug and manufacturer.
- The amount of the prescription drug.
- The name of the Pharmacy along with the telephone number and address.
- The name of the Doctor that prescribed the drug.
- Please indicate on the receipt the reason for taking each prescription.

Mail the completed claim to: **Blue Cross and Blue Shield of Alabama  
Claims Department  
Post Office Box 995  
Birmingham, Alabama 35298-0001**  
or visit our web site: **[www.bcbsal.com](http://www.bcbsal.com)**