Claim Form

to Pay Insured/Subscriber

1 0 #PY t %BMMBT 5FYBT

Each item on this form needs to be completed.
Instructions for completion are listed on the reverse side.

1

Insured/Subscriber Name (Last, First, Middle Initial)	
Mailing Address	
City and State	ZIP Code
Insured Employed?	Date of Retirement: Month

2

Group Number

Insured/Subscriber Identi cation Number (from ID card)

Patient's Full Name (Last, First, Middle)	
Patient's Sex	Patient's Date of Birth Month Day Year ________/________/__________
Patient's Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other (explain) ______________________________	

5 Was illness or injury work connected? ☐ Yes ☐ No

6 If injury, was a motor vehicle involved? ☐ Yes ☐ No

Name and address of employer

____

____

7

Is patient covered under any other health bene ts plan (besides Medicaid, Medicare or CHAMPUS)? ☐ Yes ☐ No

Insurance Co. ____

Address ____ Effective date of coverage Month Day Year ________/________/__________

Employer ____ Sex of Insured ☐ Male ☐ Female

Insured name ____ Date of birth of insured ________/________/__________

Policy # ____ Relationship to patient ______________________________

If the other coverage is primary, attach the other insurance company's Explanation of Bene ts.

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Medicare — Is the patient:

				Month Day Year
a) Entitled to bene ts under Medicare insurance (Part A)?	☐ Yes	☐ No	Effective	________/________/__________
b) Entitled to bene ts under Medicare insurance (Part B)?	☐ Yes	☐ No	Effective	________/________/__________
c) Entitled to bene ts under Medicare due to a disability?	☐ Yes	☐ No	Effective	________/________/__________

Patient's Medicare Identi cation Number. (From Medicare ID card) ______________________________

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I certify the above is complete and correct and that I am claiming bene ts only for charges incurred by the patient named above. Authorization is hereby given to any Hospital, Physician, Dentist, Provider, Insurance Carrier or other entity to give Blue Cross and Blue Shield of Texas, upon request, any medical information which the Plans in their judgment deem necessary to the adjudication of this claim. Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to nes and con nement in state prison.

Signature of Insured	Date	Daytime telephone number

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Total amount for ALL covered services and supplies received.	$
Itemized Bill(s) for covered services and supplies must be attached. (See Instructions on reverse side.)	