

PROVIDER: Please note there is no copayment or coinsurance required from member for this service.

County Health Pool Department of Transportation Physical



P.O. Box 5747
Denver, CO 80217-5747

One patient and one provider per claim form.
See reverse side for claim filing instructions.

Subscriber Submitted Claim

1. Number	2. Group no.	3. Patient name (Last, first, initial -- please PRINT)	4. Patient birthdate
5. Patient sex <input type="checkbox"/> Male <input type="checkbox"/> Female	6. Patient relationship to subscriber <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other		7. Subscriber name (Last, first, initial -- please PRINT)
8. Subscriber address (Street, City, State, ZIP code)			

COORDINATION OF BENEFITS INFORMATION -- ANSWER "YES" OR "NO" TO ALL QUESTIONS

9. Is patient covered by any other group health benefit plan? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, go to Question 10.	10. Is patient eligible for Part A and/or Medicare? Part A <input type="checkbox"/> Yes <input type="checkbox"/> No Part B <input type="checkbox"/> Yes <input type="checkbox"/> No If no, go to Question 11a.	11. Illness or symptoms -- for reimbursement Diagnosis V70.3
11a. Name of policyholder	11b. Name and address of insurance company	11c. Policy no.
12. Name of provider or hospital facility of service	13. If we have questions, who may we contact? Name _____ Phone no. _____	13a. Medicare no.
14. If place of service was outpatient hospital, provide name of hospital facility		

PLEASE COMPLETE THE FOLLOWING AS A SUMMARY OF THE ITEMIZED BILLS YOU HAVE ATTACHED TO THIS CLAIM FORM

15. Date of service	16. Place of service	17. Charge for service	18. Briefly describe the service(s) you received. Check box next to your corresponding age at the time of exam.
	22		Physical exam — 99385 (18-39 years) m
	22		Physical exam — 99386 (40-64 years) m
	22		Physical exam — 99387 (65+) m
	22		For existing patients: Physical exam — 99395 (18-39 years) m
	22		For existing patients: Physical exam — 99396 (40-64 years) m
	22		For existing patients: Physical exam — 99397 (65+) m

19. Total charges for which you are requesting Consideration of payment \$ _____	20. Place of service <input type="checkbox"/> H -- Home <input type="checkbox"/> NH -- Nursing Home <input type="checkbox"/> P -- Pharmacy <input type="checkbox"/> L -- Laboratory
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21. I certify to the accuracy and completeness of all information reported by me on this form and authorize the release of any medical information necessary to process this claim.

Signature	Date
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FULL SIGNATURE AND DATE REQUIRED ON EACH FORM. INCOMPLETE FORMS MAY DELAY PROCESSES. PLEASE ENSURE ALL FIELDS ARE ANSWERED

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reverse side for claim filing instructions.*

Subscriber Submitted Claim See

SUBSCRIBER CLAIM FILING INFORMATION *(How to file)*

Be sure to ask your provider of care if he/she bills a statement to Anthem Blue Cross and Blue Shield. Please submit statements only if the provider does not bill us directly. To receive benefits for RX, or for services by a provider who does not bill us directly, complete the claim form, attach itemized bills, and mail the white copy to Anthem Blue Cross and Blue Shield, P.O. Box 5747, Denver, Colorado 80217-5747. Keep a duplicate copy of your itemized bills as they will not be returned to you. This claim may be returned to you if all required information is not present.

CLAIM FILING INFORMATION *(Corresponds to numbered items on claim form)*

A separate claim form for each family member and each provider of care must be submitted.

ITEM NO.

- 1-8 Please complete all blocks. All fields required.
- 13 Name and telephone number; whoever can help us if additional information is required.
- 14 Indicate the name of the physician, pharmacy, hospital or other institutional facility who has billed for services provided to the patient. Only one provider per form (however, multiple pharmacy bills may be attached to one claim form.)
- 15 Statement of why these services were required.
- 16 Write the appropriate code to indicate the place of service by using the legend below this section.
- 17 Indicate the total charge for each service.
- 18 Use a separate line for each date of service and receipt. Briefly indicate the type of service, i.e. lab, X-ray, surgery, therapy, cast, stitches, etc.
- 19 This amount represents the total of all charges to be considered for benefit.
- 20 If laboratory or radiology services are being billed by a professional provider, and the place of service was inpatient or outpatient hospital, indicate the name of the hospital.
- 21 Your signature attests to the accuracy and completeness of all information on the claim and the attachments and authorizes the release of your medical records by the provider to our office if necessary.

REQUIRED INFORMATION

Itemized Bills: Summarizing the services may help us better understand the attachments if they are not clear. The attached itemized bills must include the provider name, patient's name, date of service, detailed description of service, and amount charged for that service. These must be valid documents from the provider.

Psychotherapy: Length and type of session (group or individual). Name and professional status of the individual conducting the session.

Prescription Drugs: Patient's name, pharmacy name and address, purchase date, drug name, prescription number and charge. The bill or receipt must be issued by the pharmacy.

HELPFUL HINTS

- If you have questions or need assistance, contact Anthem Blue Cross and Blue Shield Customer Service.
- To reduce the possibility of small billings getting lost or separated, it would be helpful if you attach these to an 8 1/2x11 piece of paper.
- We encourage you to file claims within 90 days of the service date. Please refer to your Benefit Certificate for specific timely filing limitations.
- File only if the provider has not.

Important: If the services for this claim were provided by a participating physician or hospital, the benefit payment will go to the provider. However, if you paid this participating provider in full, attach a copy of your cancelled check or receipt and we will direct the benefit payment to you. Indicate "PAID IN FULL".

A complete description of your benefits, as well as limitations and exclusions applicable thereto, is available in the Benefit Certificate. Final interpretation of any and all provisions of the program is governed by the Benefit Certificate.

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