

# County Health Pool Department of Transportation Physical



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

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

*One patient and one provider per claim form.*

1. Member no.	2. Group no. <b>C23225</b>	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)			

**COMPLETE THIS SECTION IF YOU HAVE OTHER HEALTH INSURANCE SO WE MAY COORDINATE BENEFITS**

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  <b>Diagnosis V70.3</b>
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.
	11		
	11		
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	11		
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	11		

19. Total charges for which you are requesting  Consideration of payment \$ _____	20. Provider Tax ID no.
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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.

Member's 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.**

*One patient and one provider per claim form.*

#### **SUBSCRIBER CLAIM FILING INFORMATION (How to file)**

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 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.

1-10 Please complete all blocks. All fields required.

11a-12 Please complete if applicable.

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 Date of service.

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 Fill in with provider's tax ID number.

21 Member's 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.

#### **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.