County Health Pool
Health Fair Claim Form

Subscriber Submitted Claim Form

Anthem BlueCross BlueShield

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

One patient and one provider per claim form.

1. Member ID no.	2. Group no.		
3. Patient name (Last, first, initial – please PRINT)	4. Patient birthdate	5. Patient sex ☐ Male ☐ Female	
6. Patient relationship to subscriber ☐ Self ☐ Spouse ☐ Child ☐ Other	7. Subscriber name (Last, first, initial – please PRINT)		
8. Subscriber street address	City	State	ZIP code

Coordination of benefits information – Answer all questions completely.

9. Is patient covered by any other group health benefit plan? ☐ Yes ☐ No (If no, go to Question 11a)		
10a. Name of policyholder	10b. Name and address of insurance company	10c. Policy no.
11a. Is patient eligible for Medicare Part A and/or Medicare Part B? (If no, go to question 12) Medicare Part A: ☐ Yes ☐ No Medicare Part B: ☐ Yes ☐ No		11b. Medicare no.
12. Illness or symptoms – for reimbursement **Diagnosis V70.0 (ICD-9) or Z0000 (ICD-10) – Routine general medical examination**		
13. Location of Health Fair (name only) **TIN 742452969**	14. If we have questions, who may we contact? Name: _____ Phone no.: _____	
15. 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.

16. Date of service	17. Place of service	18. Charge for service	19. Briefly describe the service(s) you received. (Check box next to services you have received.)
	99		☐ Health Fair labs – 80050
	99		☐ PSA – 84153

20. Total charges for which you are requesting consideration of payment $ _____	20a. ☐ PAID IN FULL. Direct benefit payment to the member.

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 **X**	Date

Full signature and date required on each form. Incomplete forms may delay processing. Please be sure all fields are answered.

Reset Form Save and Print

Subscriber claim filing information — How to file

Be sure to ask your health care provider 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 prescription drugs, or for services by a provider who does not bill us directly, complete the claim form, attach itemized bills, and mail 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 number

1-9 Please complete all blocks. All fields required.
10 Coordination of additional insurance.
11a Medicare eligibility.
14 Name and telephone no.; whoever can help us if additional information is required.
15 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.
16 Use a separate line for each date of service and receipt.
17 Pre-coded — Do not complete.
18 Indicate the total charge for each service.
19 Pre-coded — Do not complete.
20 This amount represents the total of all charges to be considered for benefit.
20a Check box if you made full payment for Health Fair services.
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.

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 1/2 x 11 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. Check box "PAID IN FULL" in item 20a.

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.