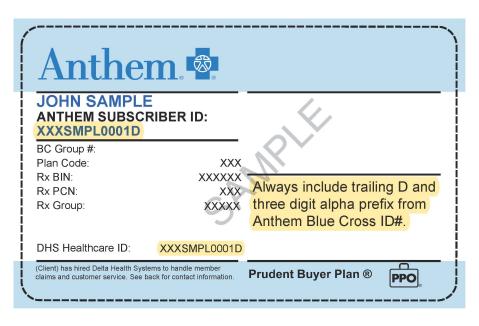


MEDICAL CLAIM FORM

PATIENT AND EMPLOYEE INFORMATION			
Anthem Blue Cross ID Number	Group #		
1. Patient's Name	2. Patient's Date	of Birth	3. Employee's Name
4. Patient Address (Street, City, State, Zip Code)	5. Patients Sex Male 7. Patients Relati Self Spou	Female onship to Employee Concording to Employee Concording to Employee Contour to Employee Contour to Employee	6. Employee's Address (Street, City, State, Zip Code) CHECK HERE IF NEW ADDRESS
8. OTHER HEALTH INSURANCE COVERAGE: Is patient covered by any other plan? Yes No			
If yes, provide name and address of carrier:			
Identification Number Name of Employer			
Types of Coverage by Carrier: Medical Drug Uision Dental			
Effective Date of Coverage Termination Date of Coverage			
9. Was condition related to accident? Yes No If yes, please give details:			
When did the accident occur? (MM/DD/YY)			
10. Was condition related to Patient's Employment?			
11. I authorize the undersigned physician to release any information acquired in the course of my examination or treatment.		12. I authorize payment of medical benefits to undersigned physician or supplier for service(s) described below.	
Signed (Employee or Patient) Date		Signed (Employee or Pat	ient) Date

REFER TO THE BACK OF YOUR I.D. CARD FOR PROPER MAILING ADDRESS



Attach itemized bill. Each itemized bill must include:

- Name and address of provider
- Provider Tax ID
- Name of patient
- · Service provided

- Date of service
- Amount charged for each service
- Diagnosis Code
- Procedure Code