BlueCross BlueShield of Iowa
An Independent Licensee of the Blue Cross and Blue Shield Association

636 Grand Avenue
Des Moines, Iowa 50309-2565

# PATIENT CLAIM FORM

PLEASE FOLLOW THE INSTRUCTIONS ON THE BACK OF THIS CLAIM FORM IN ORDER TO COMPLETE THE FOLLOWING. (ONE PATIENT PER CLAIM FORM.)

## PATIENT AND INSURED (CERTIFICATEHOLDER) INFORMATION

| | | |
|---|---|---|
| PATIENT'S NAME (LAST, FIRST, MIDDLE INITIAL) | DATE OF BIRTH<br>MO. DAY YEAR | INSURED'S NAME (LAST, FIRST, MIDDLE INITIAL) |
| PATIENT'S ADDRESS (STREET, CITY, STATE, ZIP) | PATIENT'S SEX<br>☐ MALE ☐ FEMALE<br>PATIENT'S RELATIONSHIP TO INSURED<br>☐ SELF ☐ CHILD<br>☐ SPOUSE ☐ OTHER | INSURED'S PREFIX AND IDENTIFICATION NO.<br>OTHER NUMBERS OR LETTERS AS THEY APPEAR ON YOUR IDENTIFICATION CARD |
| IS PATIENT COVERED BY ANY OTHER GROUP HEALTH POLICY, PLAN OR PROGRAM?<br>☐ NO ☐ YES, COMPLETE THE FOLLOWING<br>OTHER INSURANCE COMPANY NAME: _____<br>OTHER INSURANCE COMPANY ADDRESS: _____<br>STREET CITY<br>STATE ZIP<br>NAME OF POLICYHOLDER: _____<br>LAST FIRST INITIAL<br>POLICY NUMBER: _____<br>POLICY EFFECTIVE DATE: _____<br>OTHER INSURED'S DATE OF BIRTH _____ | WAS CONDITION RELATED TO:<br>A. PATIENT'S EMPLOYMENT?<br>☐ YES ☐ NO<br>B. AN ACCIDENT?<br>☐ YES ☐ NO<br>DATE OF ACCIDENT:<br>IF PATIENT IS OVER 18 YEARS, INDICATE IF:<br>☐ STUDENT (INCLUDE SCHOOL NAME, ADDRESS)<br>☐ DISABLED ☐ MEDICARE COVERED | INSURED'S HOME ADDRESS (STREET, CITY, STATE, ZIP)<br>☐ CHECK HERE IF NEW ADDRESS<br>INSURED'S HOME PHONE NUMBER<br>( )<br>INSURED'S WORK PHONE NUMBER<br>( ) |

## CLAIM INFORMATION (USE SEPARATE CLAIM FORM FOR EACH DOCTOR OR HOSPITAL)

| DATE OF SERVICE | NATURE OF ILLNESS |
|---|---|
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| PROVIDER NAME (DOCTOR, HOSPITAL, PHARMACY, OR OTHER) | |
| PROVIDER ADDRESS (STREET, CITY, STATE, ZIP CODE) | |

**PLEASE ENCLOSE ITEMIZED BILLS FOR SERVICES LISTED ABOVE. DO NOT STAPLE.**

I certify that the information given is complete and correct and that I am claiming benefits only for changes incurred by the patient named above. I authorize any health care provider to release medical records to Blue Cross and Blue Shield of Iowa when reasonably related to the health care claims submitted. If any law or regulation requires additional authorization for release of medical records, I will give this authorization.

SIGNED X DATE