Medical Claim Form

Please use a separate claim form for each patient and provider. Your cooperation in completing all items on the claim form and attaching all required documentation will help expedite quick and accurate processing. **See reverse side for complete instructions.**

Section 1. Patient information

Last name	First name	Middle Initial	Date of birth (MMDDYYYY)

Does the patient have other health insurance coverage? ☐ Yes ☐ No	Relation to subscriber ☐ Self ☐ Spouse ☐ Son ☐ Daughter	Sex ☐ Male ☐ Female

Name of other health insurance company	Group no.	Employer name	Policy no.

Section 2. Subscriber information (on Wellpoint ID card)

Identification no.		Group no.		
Last name		First name		M.I.
Street address	Apt. no.	City	State	ZIP code
Home phone no.	Work phone no.		Date of birth (MMDDYYYY)	

Section 3. Medical information

Use this section to report any **covered** health service that has not already been reported to Wellpoint by the provider of service (the physician, clinician, ambulance company, private-duty nurse, etc.).

Where was the service rendered? ☐ Physician office ☐ Outpatient ☐ Inpatient ☐ Ambulance ☐ Medical equipment supplier ☐ Pharmacy ☐ Laboratory ☐ Other

Was this medical expense the result of an accident? ☐ Yes ☐ No

Was this condition or injury job related? ☐ Yes ☐ No

Have you filed for workers' compensation? ☐ Yes ☐ No

When did this injury or accident occur? _____ (MMDDYYYY)

Date of service (MMDDYYYY)	**Diagnosis code**	**Procedure code**	**Tax ID**	**NPI**	**Amount**

What to include: Attach an itemized bill (or photocopy) and proof of payment was made for said services. Forms of proof of payment can include but are not limited to; a receipt, bank statement, an invoice provided by the provider that shows payment was made, or other record that shows the payment was successful.

Total $

- ▶ Name and address of provider (doctor, hospital, laboratory, ambulance service, etc.).
- ▶ Name of patient.
- ▶ Service provided.
- ▶ Date of service.
- ▶ Amount charged for each service.
- ▶ Diagnosis code.
- ▶ Procedure code.
- ▶ Tax ID no.

I certify that, to the best of my knowledge, the information on this *Medical Claim Form* is true and correct. I authorize the release of any medical information necessary to process this claim.

Signature	Printed name	Date (MMDDYYYY)
X		

How to use this form

Dear Member:

Usually, all providers of healthcare will bill us for services to you and your enrolled dependents. This is the preferred procedure. You are not bothered with claim forms, and we often need more details than are ordinarily provided on bills to patients.

Sometimes, a provider like a doctor or an ambulance company may not bill us; they may send the bill directly to you. When this happens, we have no way of knowing about your claim. This *Medical Claim Form* was developed to notify us of any covered health service for which we have not already been billed. Please read the following instructions about how to report healthcare services.

We are happy to serve you.

Section 1. Patient information

Use this section to identify the patient.

Section 2. Subscriber information

Use this section to identify the subscriber. Some of this information may be found on your Wellpoint ID card.

Section 3. Medical information

Use this section to report any **covered** health service that has not already been reported to Wellpoint by the provider of service (the physician, clinician, ambulance company, private-duty nurse, etc.). **Attach itemized bill (or photocopy) and proof of payment.** Please be sure that duplicate bills are not submitted.

For medical claims

Please send this completed claim form to:
Wellpoint
P.O. Box 4095
Woburn, MA 01888

For prescription drug claims

Non-Medicare members:

Get claim forms at caremark.com or by calling CVS Caremark at 877-876-7214.

Medicare members:

Get claim forms at gic.silverscript.com or by calling SilverScript at 877-876-7214.

If you have questions or need any assistance, please call the number listed on your Wellpoint ID card.