Patrius Health

# MEDICAL EXPENSE CLAIM

**FILL OUT A SEPARATE FORM FOR EACH PATIENT**.
Use this form to file a claim for any eligible medical expenses when your physician or other provider does not file a claim. Please **print** clearly with black ink or **type**.

**1. Patient's Name** (only one Patient per form)

| Last Name | First Name | Middle Name |
|---|---|---|
| Street Address | | |

| City | State | Zip | Daytime Telephone |
|---|---|---|---|
| | | | |

| **2. Member ID as shown on your I.D. Card** (include any letters, if applicable) | **3. Group Number** (as shown on I.D. Card) **or Place of employment** |
|---|---|
| | |

**4. Patient's Date of Birth** | **5. Patient's Gender** ☐ **Male** ☐ **Female**

**6. Is patient covered under any other group health insurance plan?** (including any other Blue Cross and Blue Shield coverage).

☐ **YES** ☐ **NO** If yes, complete the following:

**Name of Policy Holder**

| Last Name | First Name | Middle Name |
|---|---|---|
| Name and Address of Insuring Company | | |

| I.D. Number | Policy Effective Date | |
|---|---|---|
| | | |

**7. Was condition related to:**

| | | | (If **yes**,give date of accident or onset of illness): |
|---|---|---|---|
| A. Patient's Employment | ☐ **YES** | ☐ **NO** | |
| B. Auto Accident | ☐ **YES** | ☐ **NO** | |
| C. Other Accident/Injury | ☐ **YES** | ☐ **NO** | |

**8. Diagnoses** (type of illness or injury)

**9. Ordering Physician**

| Last Name | First Name |
|---|---|
| Street Address | |

| City | State | Zip | Phone |
|---|---|---|---|
| | | | |

**INSTRUCTIONS:** Attach the original bill or statement from the physician or supplier and **keep a copy for your records**.
**Make sure the bill contains all required information** (see back of form for required information). Sign this form.

I, the undersigned, furnished the above information to enable to consider this claim for payment, and I certify that such information is true and correct and that the expenses were incurred by the above named patient. **I understand that any payment will be made to me**.

| Signature | Date |
|---|---|
| | |



**SEE BACK OF CLAIM FORM FOR EASY CLAIM FILING INSTRUCTIONS**

# FILING YOUR CLAIM IS EASY

1. Fill out the Medical Expense Claim form (include all requested information).

2. Attach the bill (or clear copy of the bill) to this form.

**Your bill should include the following information: (do not attach a balance forward bill)**

- Patient's full name.
- Date of treatment.
- A description of the treatment provided (i. e. office visit, x-ray, surgery etc.)
- A diagnosis (type of illness or injury).
- Charge for each treatment.
- Place of treatment (i.e. doctor's office, hospital, one day surgery clinic, etc.)
- Date of accident (if applicable).
- Any Medical Equipment and/or supplies purchased. (Supply the invoice and be sure to complete box 9, Ordering Physician, on the front of this form.)

**Note:** The above information is usually provided on an itemized bill from the provider.)

**Members can mail the completed claim to:**

**Patrius Health**
**Attention: Blue Advantage**
**450 Riverchase Parkway East**
**Birmingham, Alabama 35244**