MEMBER CLAIM FORM

MAIL CLAIM TO:
Anthem Blue Cross and Blue Shield
P.O. Box 54159
Los Angeles, CA 90054-0159

MEMBER NUMBER	GROUP NUMBER	NUMBER OF ITEMS ATTACHED

PATIENT INFORMATION - Person who received services:

NAME (last, first, MI)	SEX	RELATIONSHIP TO SUBSCRIBER	DATE OF BIRTH
	☐ MALE ☐ FEMALE	☐ SELF ☐ CHILD ☐ SPOUSE ☐ OTHER	Mo. Day Yr.

PRIMARY MEMBER INFORMATION:

NAME (last, first, MI)			
ADDRESS	City	State	Zip Code
☐ IMPORTANT Check here if this is a new address			

OTHER COVERAGE INFORMATION:

IS THIS PATIENT COVERED BY ANY OTHER GROUP HEALTH CARE PLAN OR MEDICARE? ☐ YES ☐ NO	WAS CONDITION RELATED TO AN AUTOMOBILE ACCIDENT? ☐ YES ☐ NO WAS CONDITION RELATED TO EMPLOYMENT? ☐ YES ☐ NO

If "YES" to either of the above questions, please complete the following:

Policyholder's Name	DATE OF BIRTH Mo. Day Yr.	Policy Number		
Insurance Company's Name Anthem Blue Cross Blue Shield		Please indicate type of coverage ☐ Health ☐ Dental ☐ Vision ☐ Drug		
Insurance Company's Address P.O. Box 54159	City Los Angeles		State CA	Zip Code 90054-0159

Employer's Name	Group No.	Medicare No.	Medicare Effective Date	Medicare
TWCC Holding Corp.	174513			☐ Part A ☐ Part B

MEDICAL INFORMATION:

IS THIS AN ILLNESS ☐ OR INJURY ☐ IF INJURY, DATE OF INJURY IS REQUIRED	MO DAY YR
Describe the illness or injury which required treatment:	
How did the injury occur?	

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE - I authorize the release of any medical information necessary to process this claim and also certify that the above information is correct.	**READ THIS**	Any intentional false statement in this application or willful misrepresentation relative thereto is a violation of the law.
SIGNED	DATE	

NOTE - Please indicate the physician providing service on each bill.
If you have questions or need any assistance, please call the number listed on your Member ID card

Independent Licensee of the Blue Cross Blue Shield Association