



# Member Claim Form

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

PLEASE TYPE or PRINT · SEE REVERSE SIDE FOR COMPLETE INSTRUCTIONS

A. PATIENT INFORMATION			B. SUBSCRIBER INFORMATION (on your Health Plan ID Card)		
NAME Last		First	Middle Initial	MEMBER ID	GROUP NUMBER
				DGA                     J	276945M
BIRTHDATE	SEX	RELATION TO SUBSCRIBER		NAME Last	First
	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Son <input type="checkbox"/> Daughter			Middle Initial
DOES THE PATIENT HAVE OTHER HEALTH INSURANCE COVERAGE?			ADDRESS		
<input type="checkbox"/> Yes <input type="checkbox"/> No					
NAME OF OTHER HEALTH INSURANCE COMPANY			CITY	STATE	ZIP CODE
POLICY NUMBER			HOME PHONE NO.	WORK PHONE NO.	
			( )	( )	

## C. MEDICAL INFORMATION

**HEALTH CARE SERVICES:** Use this section to report any COVERED health service that has not already been reported to this Anthem Blue Cross Plan by the provider of service (the physician, clinical, ambulance company, private duty nurse, etc.) Attach itemized bill or photocopy. Please be sure that duplicate bills are not submitted.

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

On what day did this injury or accident occur? ..... Month: \_\_\_\_ Day: \_\_\_\_ Year: \_\_\_\_

Have you been treated for the same condition within the last 24 months? .....  YES  NO

If yes, indicate date you were last treated: ..... Month: \_\_\_\_ Day: \_\_\_\_ Year: \_\_\_\_

DATE OF SERVICE (Mo/Day/Yr)	PROVIDER OF SERVICE (Name of Doctor, Lab, Amb. Co., etc.)	PLACE OF SERVICE (Choose from menu)	ILLNESS OR DIAGNOSIS	TOTAL

If the bill is from a Licensed Clinical Social Worker; Marriage, Family and Child Counselor; Audiologist; or Occupational, Physical, or Speech Therapist; what is the name of the physician who ordered the service?

Dr. \_\_\_\_\_

**GRAND TOTAL**  
\$

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

**X** \_\_\_\_\_  
SIGNATURE OF SUBSCRIBER DATE

## HOW TO USE THIS FORM

Dear Member:

Usually, all providers of health care 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 physician may not bill us or an ambulance company, for example, they may send the bill directly to you. In either instance, we have no way of knowing about your claim. This Member 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 Health Care Services.

We are happy to serve you.

## SECTION A. PATIENT INFORMATION

Use this section to identify the patient.

## SECTION B. SUBSCRIBER INFORMATION (on your Health Plan ID card)

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

The image shows a Health Plan ID card with the Anthem logo and 'DGA-PRODUCER HEALTH PLAN' text. The card has several fields: 'YOUR NAME' (blank), 'Identification Number' (DGA123456781), 'Group No.' (276945XXXX), 'Plan Code:' (D10), and 'Coverage(s):' (Medical). A red circle highlights the Identification Number, and a green circle highlights the Group No. Red and green arrows point from these circles to the text 'Your identification number' and 'Your group number' respectively.

Your identification number

Your group number

## SECTION C. MEDICAL INFORMATION: This section pertains to the employee through whose employer your program is obtained

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## WHERE TO SUBMIT THIS FORM



### ONLINE (Recommended):

You must first be a registered user of Anthem.com to submit your claims online.

1. Log onto Anthem.com
2. Under the *My Plan* tab, click *Claims*.
3. On the *Claims* page, click *Submit a Claim*.
4. On the *Submit a Claim* page, complete the requested information, attach copies of your itemized bills, and click *Next*.
5. Complete your contact information and click *Next*.
6. Check the box attesting to the accuracy of your claim information and click *Submit*. You will receive onscreen confirmation when your claim has been submitted.

For technical assistance with the online claims submission process, contact Anthem Blue Cross at (866) 755-2680.

### BY FAX:

Choose one of the following toll-free fax numbers:

(866) 896-1393      (866) 896-6626  
(866) 896-6531      (866) 896-6532

When faxing your claim, be sure to keep your fax confirmation sheet for your records.

**NOTE:** If you have Caller ID Block installed on your phone line, you will need to temporarily disable the feature by dialing \*82 before faxing your claim to Blue Cross.

### BY MAIL: DO NOT submit claims to the Health Plan Office

Mail your claim directly to Blue Cross at the address below:

**Anthem Blue Cross**  
P.O. Box 60007  
Los Angeles, CA 90060-0007

## HOW TO CHECK THE STATUS OF YOUR CLAIM

- **Anthem Blue Cross Benefits Portal:** The Anthem Blue Cross Benefits Portal provides up-to-the-minute status of your medical claims as well as other information like your progress towards your annual deductible. To register for the Anthem Blue Cross Benefits Portal, go to [www.anthem.com/ca](http://www.anthem.com/ca).
- **myPHP Online Benefits Portal:** The myPHP online benefits portal lets you view, download and print your Explanations of Benefits as your claims are processed by the Plans' office. With myPHP, you can also check your estimated pension benefits, check your Health Plan eligibility status, verify your pension and health contributions, and more. To create a myPHP account, have your Plan ID ready and go to [www.dgaplans.org/myphp](http://www.dgaplans.org/myphp).

If you have questions or need any assistance, please call (877) 866-2200 ext. 401.