DELTA HEALTH SYSTEMS

MEDICAL CLAIM FORM

PATIENT AND EMPLOYEE INFORMATION		
Anthem Blue Cross ID Number	Group #	
1. Patient's Name	2. Patient's Date of Birth | |	3. Employee's Name
4. Patient Address (Street, City, State, Zip Code)	5. Patients Sex ☐ Male ☐ Female 7. Patients Relationship to Employee ☐ Self ☐ Spouse ☐ Child ☐ Other	6. Employee's Address (Street, City, State, Zip Code) ☐ CHECK HERE IF NEW ADDRESS

8. OTHER HEALTH INSURANCE COVERAGE: Is patient covered by any other plan? ☐ Yes ☐ No

If yes, provide name and address of carrier:_____

Identification Number_____ Name of Employer_____

Types of Coverage by Carrier: ☐ Medical ☐ Drug ☐ Vision ☐ Dental

Effective Date of Coverage_____ Termination Date of Coverage_____

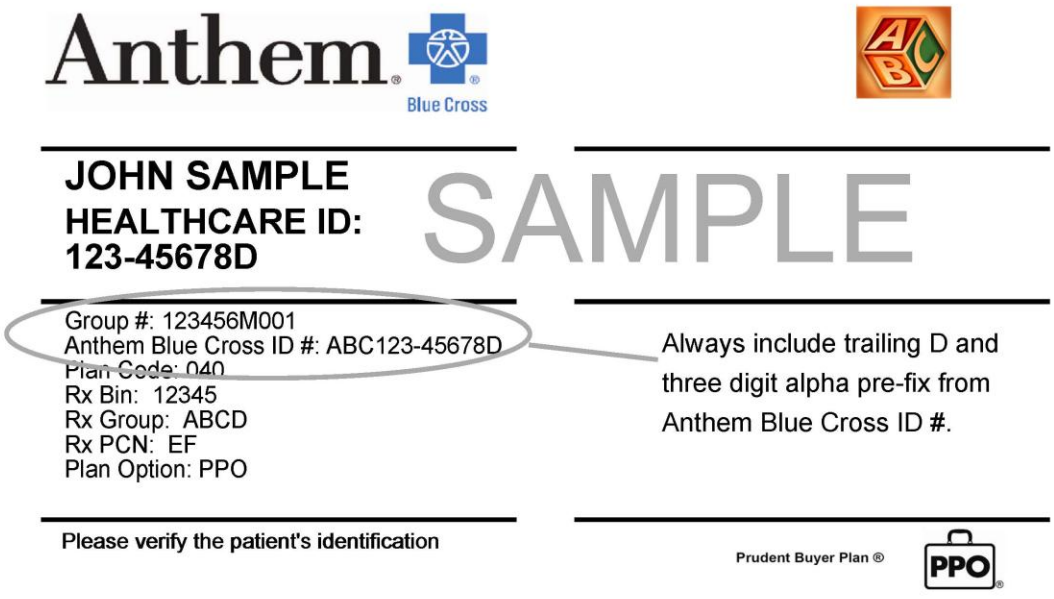
9. Was condition related to accident? ☐ Yes ☐ No If yes, please give details:

When did the accident occur? (MM/DD/YY) _____

10. Was condition related to Patient's Employment? ☐ Yes ☐ No When did the injury occur? (MM/DD/YY) _____

11. I authorize the undersigned physician to release any information acquired in the course of my examination or treatment.	12. I authorize payment of medical benefits to undersigned physician or supplier for service(s) described below.
_____ Signed (Employee or Patient) Date	_____ Signed (Employee or Patient) Date

REFER TO THE BACK OF YOUR I.D. CARD FOR PROPER MAILING ADDRESS



Attach itemized bill. Each itemized bill must include:

- Name and address of provider
- Provider Tax ID
- Name of patient
- Service provided
- Date of service
- Amount charged for each service
- Diagnosis Code
- Procedure Code