ITEMIZED BILLS FOR COVERED SERVICES OR SUPPLIES MUST BE ATTACHED AND THE ITEMIZED BILLS MUST CONTAIN:

NAME OF THE PERSON OR ORGANIZATION PROVIDING THE SERVICES OR SUPPLIES
NAME OF THE PATIENT RECEIVING THE SERVICES OR SUPPLIES
EACH DATE THE SERVICES OR SUPPLIES WERE PROVIDED
EACH CHARGE FOR THE SERVICES OR SUPPLIES
DESCRIPTION OF THE SERVICES OR SUPPLIES

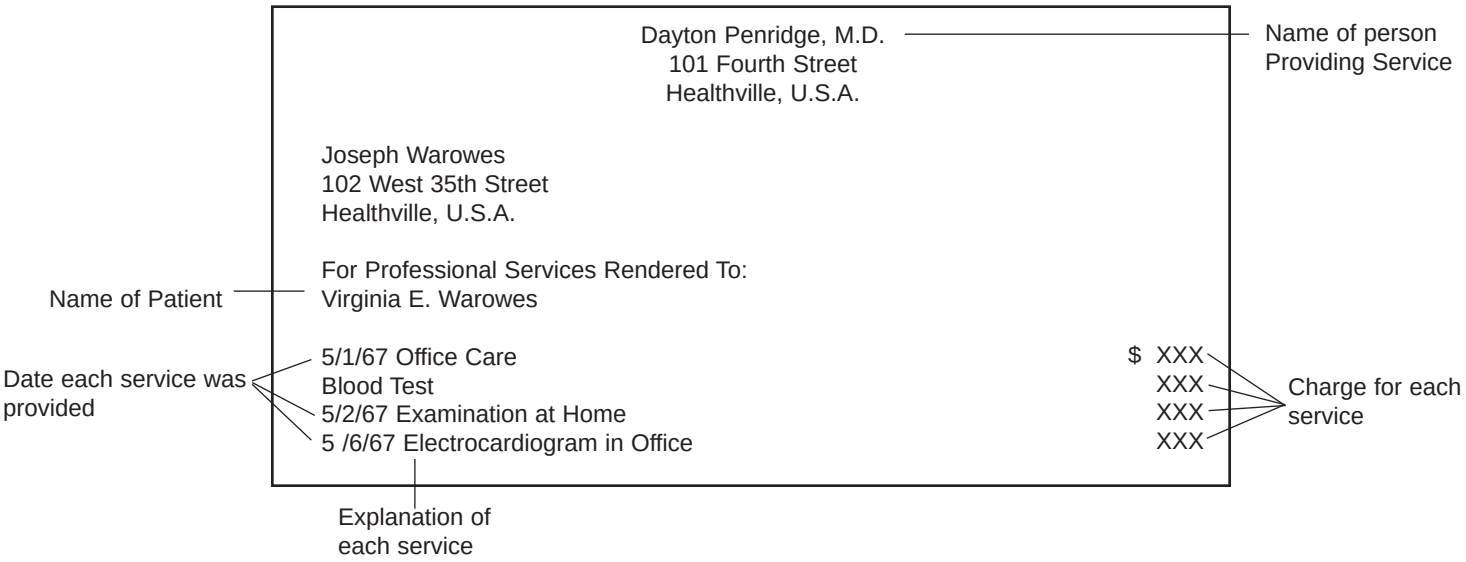
IN ADDITION

BILLS FOR SPECIAL NURSING SERVICE MUST SHOW THE PROFESSIONAL STATUS OF THE NURSE, SUCH AS R.N. (REGISTERED NURSE) AND REGISTRATION NUMBER (INCLUDE SHIFT(S) WORKED AND DATE(S))

BILLS FOR PRESCRIPTION DRUGS MUST SHOW THE PRESCRIPTION NUMBERS FOR EACH DRUG

ITEMIZED BILLS CANNOT BE RETURNED

EXAMPLE OF ITEMIZED BILL:



This Completed Form, Together With the Itemized Bill And Supporting Material May Be Submitted To:

BLUE CROSS AND BLUE SHIELD OF FLORIDA, INC.
P.O. Box 1798 - 532 Riverside Avenue
Jacksonville, Florida 32231-0014

"Any person who knowingly and with intent to injure, defraud, or deceive any insurance company files a statement of claim containing any false, incomplete or misleading information is guilty of a felony of the third degree."

Florida Statutes, Section 817.234

[redacted]

DO NOT WRITE IN THIS BLOCK

MAJOR MEDICAL/COMPREHENSIVE CLAIM FORM

Blue Cross Blue Shield of Florida

P. O. Box 1798
532 Riverside Avenue
Jacksonville, Florida 32231-0014

Please refer to your identification card for your **toll-free** customer service telephone number.

PART I — COMPLETE

PATIENT'S LAST NAME	FIRST	MI	CONTRACT NUMBER	SEX	DATE OF BIRTH
				M F	mo. day yr.

RELATIONS OF PATIENT TO SUBSCRIBER

- ☐ Subscriber (SUB)
- ☐ Spouse (SPO)
- ☐ Son (SON)
- ☐ Daughter (DAU)
- ☐ Handicapped Dependent (HDP)
- ☐ Sponsored Dependent (SDP)
- ☐ Other (OTH)

WAS CONDITION RELATED TO:

A. Auto Accident? Date - Yes ☐ No ☐

B. Patients employment? Yes ☐ No ☐

Is patient dependent and a full time student at an accredited college or university? Yes ☐ No ☐ If yes, enter college / university name and address (include zip code)

Subscriber's name and address (include zip code) permanent address? Yes ☐ No ☐

Patients place of employment - Name and address (include zip code)

Subscriber's place of employment - Name and address (include zip code)

IF THERE IS ANY INSURANCE OTHER THAN YOUR BASIC BLUE CROSS AND BLUE SHIELD APPLICABLE TO THE EXPENSES AND SERVICES CONNECTED WITH THIS ILLNESS CHECK YES AND COMPLETE INFORMATION Yes ☐ No ☐

IS INSURANCE OBTAINED THROUGH EMPLOYER? Yes ☐ No ☐	POLICY NUMBER	EFFECTIVE DATE	Name and address of insurance company (include zip code)
NAME OF INSURED		TYPE COVERAGE Single ☐ Family ☐	

HAS OTHER INSURANCE PAID? Yes ☐ No ☐ (IF YES INCLUDE COPY OF SUMMARY OF BENEFITS)

PLEASE INDICATE NATURE OF ILLNESS (ES) AND NAME OF PHYSICIAN(S)

NATURE OF ILLNESS	IF ACCIDENT GIVE DATE	NAME OF PHYSICIAN (SIGNATURE NOT REQUIRED)

SUBSCRIBERS Certification: I certify that all information provided on this form and on the attached itemized statement are true and correct to the best of my knowledge.	Subscriber's Signature	Date	Telephone Number Area Code -

PART II — COMPLETE FOR ASSIGNMENT OF PAYMENT ONLY

ASSIGNMENT OF BENEFITS: I authorize payment of benefits to the undersigned physician, hospital or supplier of service described above. If none of the blocks are checked and the name of the physician, hospital or supplier does not appear, payment will be made to the subscriber except in those cases where the provider rendering the service maintains participating contracting status with Blue Cross and Blue Shield of Florida, Inc. In such cases, payment will go directly to the provider unless there is an indication that the bill has been paid in full.

SUBSCRIBER'S SIGNATURE_____

NAME AND ADDRESS (INCLUDE ZIP CODE) OF:

Physician ☐ Hospital ☐ Supplier ☐

4240-1193R SR

Reset