



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

MEMBER CLAIM FORM

MEMBER NUMBER	GROUP NUMBER 270004 - Standard Motor Products, Inc.	NUMBER OF ITEMS ATTACHED
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PATIENT INFORMATION - Person who received services:			
NAME (last, first, MI)	SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	RELATIONSHIP TO SUBSCRIBER <input type="checkbox"/> SELF <input type="checkbox"/> CHILD <input type="checkbox"/> SPOUSE <input type="checkbox"/> OTHER	DATE OF BIRTH Mo. Day Yr.

PRIMARY MEMBER INFORMATION:			
NAME (last, first, MI)			
ADDRESS		City	State Zip Code
<input type="checkbox"/> 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? <input type="checkbox"/> YES <input type="checkbox"/> NO	WAS CONDITION RELATED TO AN AUTOMOBILE ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	
	WAS CONDITION RELATED TO EMPLOYMENT? <input type="checkbox"/> YES <input type="checkbox"/> 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	Please indicate type of coverage <input type="checkbox"/> Health <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Drug	
Insurance Company's Address	City	State Zip Code

Employer's Name	Group No.	Medicare No.	Medicare Effective Date	Medicare <input type="checkbox"/> Part A <input type="checkbox"/> Part B
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MEDICAL INFORMATION:			
IS THIS AN ILLNESS <input type="checkbox"/> OR INJURY <input type="checkbox"/>	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