

STATE OF NEW HAMPSHIRE
VISION HARDWARE
REIMBURSEMENT FORM



— IMPORTANT —

Please read and follow the instructions located on the front and back of this form. You are required to complete all unshaded areas of the form by printing clearly with a non-erasable ink pen. **This form will be returned to you if you do not provide the required information and attach an itemized bill from a doctor or supplier to the back of this form.**

1. PATIENT'S NAME (Last) (First) (M.I.)			2. PATIENT'S DATE OF BIRTH MONTH DAY YEAR		3. SUBSCRIBER'S CERTIFICATE NUMBER (INCLUDE ALPHA PREFIX) PREFIX _____			
4. PATIENT'S RELATIONSHIP TO SUBSCRIBER SELF <input type="checkbox"/> 1. SPOUSE <input type="checkbox"/> 2. CHILD <input type="checkbox"/> 3. OTHER <input type="checkbox"/> 4. SAME LAST NAME DEPENDENT			5. PATIENT'S SEX MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>		6. SUBSCRIBER'S GROUP NUMBER (FOUND ON ID CARD)			
8. WAS CONDITION RELATED TO: NOT APPLICABLE A. PATIENT'S EMPLOYMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO B. ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO			9. DATE ACCIDENT OR INJURY OCCURRED MO. DAY YR. NOT APPLICABLE		10. SUBSCRIBER'S ADDRESS STREET _____ CITY _____ STATE _____ ZIP _____ <input type="checkbox"/> NEW ADDRESS			
11. IS THE PATIENT COVERED UNDER ANY OTHER HEALTH INSURANCE POLICY? (If yes, indicate name of company and identification number) <input type="checkbox"/> YES <input type="checkbox"/> NO COMPANY NAME _____ IDENTIFICATION NUMBER _____					12. PROVIDER INFORMATION - WHERE YOU PURCHASED YOUR HARDWARE NAME _____ STREET _____ CITY _____ STATE _____ ZIP _____			
14. NAME(S) OF ILLNESSES OR INJURIES FOR WHICH THE PATIENT WAS TREATED 1. NOT APPLICABLE			DIAGNOSIS CODE		BILLING PROVIDER I.D.		PAY CODE	
2.					EIN/SSN I.D.SSState			
3.					13. REFERRING DOCTOR (DOCTOR WHO REFERRED PATIENT FOR TREATMENT) NAME NOT APPLICABLE			
4.					STREET _____ CITY _____ STATE _____ ZIP _____			
TYPE OF BILL					REFERRING PROVIDER I.D.			
					DO NOT WRITE IN SHADED AREA			
15. DATE OF PURCHASE (Mo/Day/Yr)	16.* PLACE OF SERVICE	REVENUE CODE	PROCEDURE CODE	17. DESCRIPTION OF SERVICE	DIAGNOSIS CODE	18. CHARGES	UNITS	ATTENDING PHYSICIAN I.D.
* EXPLANATION OF BLOCK 16: PLEASE INDICATE ONE OF THE FOLLOWING CODES TO IDENTIFY WHERE EACH SERVICE WAS PROVIDED.					TOTAL SERVICES	TOTAL CHARGE	TOP 1 1	
DOCTOR'S OFFICE1 INDEPENDENT LAB6					19. ATTENDING DOCTOR (DOCTOR WHO TREATED PATIENT)			
PATIENT'S HOME2 HOME HEALTH AGENCY7					NAME NOT APPLICABLE			
HOSPITAL/INPATIENT (BED PATIENT)3 AMBULANCE8					STREET _____			
NURSING HOME (SKILLED NURSING FACILITY)4 DURABLE MEDICAL EQUIP. SUPPLIER9					CITY _____ STATE _____ ZIP _____			
HOSPITAL/OUTPATIENT (EMERGENCY ROOM)5 PHARMACY (M & S SUPPLIES/DME)P								
20. I AUTHORIZE THE RELEASE TO ANTHEM BLUE CROSS AND BLUE SHIELD OF ANY INFORMATION NECESSARY TO PROCESS THIS CLAIM. SIGNATURE OF SUBSCRIBER _____							21. DATE FORM COMPLETED	

THE PERSON SIGNING THIS FORM IS ADVISED THAT THE WILLFUL ENTRY OF FALSE OR FRAUDULENT INFORMATION RENDERS YOU LIABLE TO PROSECUTION.

SUBMISSION INSTRUCTIONS

- Place itemized bill behind the completed Subscriber Claim Form. Send the completed Subscriber Claim Form and itemized bill to:

Anthem Blue Cross and Blue Shield
PO Box 533
North Haven, CT 06473-0533

- This form is to be completed by the subscriber; accompanied by a copy of a doctor's or supplier's itemized bill and submitted to Anthem Blue Cross and Blue Shield for benefit consideration.
- Submit a completed Subscriber Claim Form for each patient with an itemized bill for that patient, as soon as a provider's itemized bill is received.

EACH ITEMIZED BILL OR RECEIPT MUST CONTAIN:

- Name and address of doctor or supplier
- When the itemized bill or receipt lists the names of several doctors or suppliers, please circle the name and address of the individual who treated the patient.
- Patient's name
- Date of purchase
- Complete description of hardware (glasses or contact lenses)
- Purchase price

- **PLEASE RETAIN COPIES OF ITEMIZED BILLS, RECEIPTS OR EXPLANATION OF BENEFITS FOR YOUR RECORDS AS THEY WILL NOT BE RETURNED TO YOU.**

- **DATA BLOCKS REQUIRING SPECIAL ATTENTION**

BLOCK 3 —You must include the 3-letter prefix, which is part of your Subscriber Certificate Number as found on your ID card.

BLOCK 4 —Check OTHER when a dependent child's last name differs from the subscriber's last name

BLOCK 10 —Check NEW ADDRESS when subscriber's address is different from previous submission.

- **QUESTIONS OR PROBLEMS**

If you have any questions regarding the completion of this form, or require additional Subscriber Claim Forms, please contact the Customer Service Center at the address listed below or call the Customer Service Number listed on the back of your Identification Card.

ADMINISTRATIVE OFFICE

Anthem Blue Cross and Blue Shield
PO Box 660
North Haven, CT 06473-0660