KERN LEGACY
Max Choice
ANTHEM NETWORK HEALTH PLAN

MEMBER MEDICAL CLAIM FORM INSTRUCTIONS

1. For your protection, California law requires the following statement to appear on these instructions: "Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison."

2. Fill out a separate form for each submitting bills for covered services.

3. To avoid any delay be sure to answer each question completely.

4. If you received this form electronically, you can fill in the fields by clicking your mouse in the boxes to make a check mark. You can also type free form by placing your cursor in the sunken information fields.

5. Please print clearly and use black ink.

6. Please attach fully itemized bills for covered services or supplies. Itemized Bills must include all of the following:
    a. Subscriber Name
    b. Patient Name
    c. ID Number from your ID card
    d. Procedure code and/or description of procedures, services or supplies provided
    e. Provider Name
    f. Provider Address
    g. Provider Tax ID Number
    h. Date(s) of Service
    i. Diagnosis code(s) and/or diagnosis description(s)
    j. Charge for each service

7. If you are seeking reimbursement, please include one of the following:
    a. Front and back of cancelled check written to the provider or the bank encoded front of the check written to the provider.
    b. Credit card statement or receipt.
    c. Statement from the provider, on the provider's letterhead with authorized signature, indication payment was made.

Please send all of the required information to the claims address listed on your ID card. Your claim will be processed as quickly as possible.

If you have any questions, please contact Member Services at 1-855-537-6767 for assistance.

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MEMBER MEDICAL CLAIM FORM

SUBSCRIBER INFORMATION	GROUP NAME: **COUNTY OF KERN**
SUBSCRIBER NAME:	SUBSCRIBER ID#: **KEKCK**
SUBSCRIBER ADDRESS:	SUBSCRIBER PHONE:

PATIENT INFORMATION		
PATIENT NAME:	DATE OF BIRTH:	PATIENT SEX: MALE ◯ FEMALE ◯
PATIENT ADDRESS:		
AT THE TIME MEDICAL SERVICE WAS PROVIDED WAS THE PATIENT: Employed Full-Time ◯ Student Full-time ◯		

CLAIM INFORMATION	
CLAIM DUE TO: ◯ ILLNESS ◯ ACCIDENT	DID ILLNESS/ACCIDENT RESULT FROM EMPLOYMENT? ◯ YES ◯ NO
DESCRIPTION:	LOCATION OF ACCICENT:
IF ACCIDENT PROVIDED DATE AND TIME OF ACCIDENT:	

OTHER HEALTH INSURANCE INFORMATION			
IS PATIENT PRESENTLY COVERED BY OTHER INSURANCE, INCLUDING MEDICARE? ◯ YES ◯ NO		FOR MEDICARE, PATIENT IS ENROLLED IN: ◯ PART A ◯ PART B EFFECTIVE DATE:	
NAME OF OTHER INSURANCE:	MEMBER ID#:	EFFECTIVE DATE:	
INSURANCE ADDRESS	CITY	STATE	ZIP CODE
NAME OF INSURED:		DATE OF BIRTH:	
EMPLOYER	EMPLOYER ADDRESS	CITY, STATE	ZIP CODE

AUTHORIZATION TO OBTAIN AND RELEASE MEDICAL INFORMATION		
AUTHORIZATION TO PAY BENEFITS TO THE PROVIDER: I hereby authorize payment directly to the Provider of the Surgical and/or Medical Benefits, if any, otherwise payable to me for the services as described on the attached bill(s) but not to exceed the reasonable and customary charges for those services.	SIGNATURE	DATE
AUTHORIZATION TO REALEASE INFORMATION: I hereby authorize the undersigned Physician to release any information acquired in the course of my examination or treatment.	SIGNATURE	DATE

Print Clear