EME PLAN CLAIM FORM

Frontier Communications CWA Local 1170

Submit claims to:
Anthem Blue Cross and Blue Shield
Attn: Frontier ESR
Mailpoint: IN0201-D485
P.O. Box 166
Indianapolis, IN 46206-0166

PERSONAL INFORMATION

Name (Employee, Retiree, or Survivor): ____

Address: ____

City: _______________________________ **State:** _____ **Zip Code:** ____________

ID Number: CZT________________________ **Group Number: 270196M61A**

PATIENT INFORMATION

Patient's Name: ____

ID number: CZT ________________ **Group Number: 270196M61A**

Patient's Date of Birth (mm/dd/yyyy): ____ /____ /______

Relationship of Patient: Self Husband Wife Daughter Son

Stepson/legal guardian Stepdaughter/legal guardian

Reason For Claim (circle one): Prescription Medical **Total Amount:** $________________________

AUTHORIZATION TO RELEASE INFORMATION:

I authorize any insurance company, employer, organization, or provider of service to release any information related to this claim to Anthem Insurance Companies, Inc., or its authorized contractor before or after payment.

I have reviewed the accompanying charges and my signature below verifies their accuracy and authorizes payments as indicated:

Signature: ____ Date: ________________________

FRONTIER COMMUNICATIONS SOLUTIONS EME PLAN CLAIM FORM FILING INSTRUCTIONS

1. Complete a separate claim form for each patient.

2. Complete the Personal Information section. (Please print clearly)

3. Complete the Patient Information section. (Please print clearly)

4. Attach all corresponding bills. All bills must show:
    - Patient name
    - Date of service
    - Copy of the explanation of benefits showing the qualifying Out of Pocket expenses
    - Type of service
    - Procedure code or prescription number and prescription name
    - Amount of charge for services
    - Provider Federal Tax ID number (if available)
    - Provider address

Keep a copy of all bills for your records.

5. If the patient has Medicare or other group health insurance coverage that is primary (pays first):
    - Submit your claim to the primary coverage first
    - After the primary coverage has processed your claim, complete an Anthem Blue Cross and Blue Shield claim form
    - Attach the explanation of benefits (EOB) from the primary coverage and a copy of the original bill to the claim form
    - Submit your claim to Anthem Blue Cross and Blue Shield for processing at:

Anthem Blue Cross and Blue Shield
Attn: Frontier ESR

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All health claims must be submitted within 12 months of the date of service to be eligible.

*** In Connecticut: Anthem Blue Cross and Blue Shield is the trade name of Anthem Health Plans, Inc. Independent licensee of the Blue Cross and Blue Shield Association.**