EME PLAN CLAIM FORM

Frontier Communications CWA Local 1170

Direct Mail all claims to:
Anthem Blue Cross and Blue Shield
Attn: Andrea Rady - ESR
Mailpoint IN0201-D485
P.O. Box 166
Indianapolis, IN 46206-0166

EMPLOYEE/RETIREE/SURVIVOR PERSONAL INFORMATION (Please print clearly)

Name (Employee, Retiree, or Survivor)

Address_____

City/State_____

ZipCode_____

Alpha Prefix/Social Security/ID Number:_____

PATIENT INFORMATION

Patient's Name:_____

Patient's Alpha Prefix/Social Security/ID Number: ___ ___ ___- ___ ___ ___ - ___ ___ - ___ ___ ___ _____

Patient's Date of Birth (mm/dd/yy): _____

Relationship of Patient: Self Husband Wife Daughter Son Stepdaughter/legal guardian Stepson/legal guardian

Does patient have Medicare coverage? No Yes

Medicare Part A (Hospital) Medicare Part B (Doctor)

Effective date of Medicare Part A _____ Effective date of Medicare Part B _____

Reason for Claim:

Prescription Services Medical Services

Amount of Expenses to be considered: $_____

PROVIDER INFORMATION Name_____

Billing Address :_____ Provider Phone Number_____

Provider's Tax ID_____

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**:_____ Pay Member

Patient's (even if employee) or parent or guardian of minor

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 a 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 Blue Shield
Attn: Andrea Rady - ESR
Mailpoint IN0201-D485
PO Box 166
Indianapolis, IN 46206-0166

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