Member Claim Form
for all health care services

PO Box 27401
Richmond, Virginia 23279

Member Services: 358-7390 (Richmond Area)
Outside Richmond: 1-800-421-1880

Anthem HealthKeepers
Offered by HealthKeepers, Inc.

This claim form is designed to help you, the member, or your health care professional, file your itemized health care related bills. Most health care professionals will file claims for you. If, for some reason, your health care professional cannot file the claim on your behalf, you may use this form to claim benefits. Please review your health care bills at least once a month to assure timely filing of your claims. For prompt service, please follow these steps:

1. Assemble all itemized health care bills.
2. Separate your bills for each family member.
3. Complete a separate claim form for each family member.

Please attach the following when filing services for:

Doctors:	itemized bill or local Blue Shield form or AMA form
Dentists:	itemized bill, Blue Shield form, or local ADA form
Hospital:	itemized bill, hospital form, or the UB form
Prescription drugs:	itemized bill
Home care equipment:	itemized bill and letter of medical necessity from your physician

NOTE: If you have Medicare coverage, you must attach your Medicare Explanation of Benefits along with your itemized bills.

An itemized bill must include:

- Patient name
- Name of health care professional
- Address
- Professional status
- Date of each service
- Description and charge for each service (prescription number if drugs)

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SECTION 1: PATIENT INFORMATION

1. Patient last name	First name	M.I.	2. Patient date of birth	3. Member ID no. (include any letters)

4. Patient street address	City	State	ZIP code

5. Patient relationship to member	6. Patient sex	7. Was condition related to:
(1) ☐ Self (2) ☐ Spouse (3) ☐ Child ☐ Other: _____	(1) ☐ Male (2) ☐ Female	☐ Employment ☐ Auto accident

8. Was treatment required for:	If injury, date of injury (MM/DD/YYYY)	9. Date patient first consulted doctor for this condition (MM/DD/YYYY)
(1) ☐ Illness (2) ☐ Injury		

10. Diagnosis or symptoms:

11. Have you paid for itemized services?	12. Does patient have other insurance coverage?	13. If yes to question 12, insurance policy no.
☐ Yes ☐ No	☐ Yes ☐ No If yes, type of policy: ☐ Group ☐ Individual	

14. Complete the following if you have other coverage:

Member name	Name and address of insurance company	Employer providing group coverage

15. I certify that the information I have given is accurate to the best of my knowledge and that I, as the Participant, am claiming benefits only for charges incurred by the patient identified above. I authorize any medical professional, medical care institution, or any other provider of health care services or supplies to furnish to HealthKeepers, Inc. information concerning services or supplies provided to me for the purposes of review, investigation or payment of a claim. This authorization is valid for the duration of coverage. I understand that a copy of this authorization is available to me or my authorized representative upon request.

Signature	Date
X	

Benefits for covered services rendered outside the Anthem HealthKeepers primary service area may be paid to the policyholder or the provider of services.

SECTION 2: PROVIDER INFORMATION — Required

Provider last name	First name	M.I.	State professional license no.

Street address	City	State	ZIP code	IRS Tax ID or social security no.

Type of provider: ☐ MD/DO ☐ DDS ☐ Podiatrist ☐ Clinical psychologist ☐ Hospital ☐ Other, must specify: _____

Benefits for covered services rendered outside the HealthKeepers, Inc. service area are limited to emergencies in which care is required immediately or unexpectedly. Elective care or care required as a result of circumstances which could reasonably have been foreseen prior to departure from the service area is not covered.

SECTION 3: POLICYHOLDER SIGNATURE — Required

Member signature	Date
X	