luminare health

Submitting Medical Claims for Reimbursement

Most of the time, when you receive care, your provider sends the claim to Anthem to be processed.

However, in some cases a provider may require you to pay the claim at the point of care. If this happens, you should complete the Anthem Member Claim Form and send it with any additional supporting documents directly to Anthem to receive the full benefits of your plan. Please read the following instructions about how to complete the form.

SECTION A: Patient Information

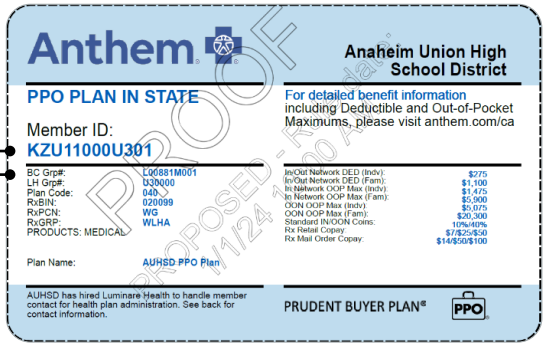
- Complete all the fields that apply.
- If the patient does not have other health insurance, leave the following fields blank:
  - Name of other health insurance company
  - Group no.
  - Employer name
  - Policy no.

SECTION B: Subscriber Information

- Complete all the fields.
- Your Identification no. is shown as Member ID on your ID card.
- Your Group no. is shown as BC Grp# on your ID card.

Identification Number

Group Number



REMEMBER:

To avoid any delays, please fill out the form completely before you submit it. On this form, "subscriber" refers to the AUHSD employee. The subscriber may also be the patient.

SECTION C: Medical Information

- Complete all the fields.
- IMPORTANT: An itemized bill must be submitted with your completed form. An itemized bill is more than a receipt and must include the following information:
  1. **Provider's name, address, and tax ID number**
  2. **Name of patient**
  3. **Date of service**
  4. **Service provided**
  5. **Amount charged for each service**
  6. **Procedure code**
  7. **Diagnosis code**

Your provider can give you the tax ID number, procedure code, and diagnosis code.

Check and Submit

Before submitting, make sure all applicable fields are completed, your itemized bill is attached, and that you've signed and dated the form. Please allow up to 30 days for processing.

Submit California Claims to:

Anthem Blue Cross
P.O. Box 60007
Los Angeles, CA 90060

For all other claims:

Call Luminare Health Customer Service at 1-866-280-4120 for your state's address.

If you have questions, please call Luminare Health Customer Service at 1-866-280-4120.

Member Claim Form

Anthem Blue Cross

Please use a separate claim form for each patient. Your cooperation in completing all items on the claim form and attaching all required documentation will help expedite quick and accurate processing. SEE REVERSE SIDE FOR COMPLETE INSTRUCTIONS.

Section A. PATIENT INFORMATION

Last name	First name	M.I.

Does the patient have other health insurance coverage?	Relation to subscriber	Sex	Date of birth (MM/DD/YYYY)
☐ Yes ☐ No	☐ Self ☐ Spouse ☐ Son ☐ Daughter	☐ M ☐ F	

Name of other health insurance company	Group no.	Employer name	Policy no.

Section B. SUBSCRIBER INFORMATION (on Anthem Blue Cross card)

Identification no.	Group no.

Last name	First name	M.I.

Street address (please include apt. no.)

City	State	ZIP code

Home phone no.	Work phone no.	Date of birth (MM/DD/YYYY)
( )	( )	

Section C. MEDICAL INFORMATION

HEALTH CARE SERVICES: Use this section to report any COVERED health service that has not already been reported to this Anthem Blue Cross Plan by the provider of service (the physician, clinical, ambulance company, private duty nurse, etc.) **Attach itemized bill or photocopy**. Please be sure that duplicate bills are not submitted.

Was this medical expense the result of an accident? ☐ Yes ☐ No

Was this condition or injury job related? ☐ Yes ☐ No

Have you filed for Workers' Compensation? ☐ Yes ☐ No

When did this injury or accident occur? (MM/DD/YYYY) ____/____/_____

Diagnosis code	Procedure code	Tax ID

BILLS MUST BE ITEMIZED

Cancelled checks, cash register receipts and non-itemized "balance due" statements cannot be processed. Each itemized bill must include:

- Name and address of provider (doctor, hospital, laboratory, ambulance service, etc.)
- Name of patient
- Service provided
- Date of service
- Amount charged for each service
- Diagnosis code
- Procedure code
- Tax ID

I certify that, to the best of my knowledge, the information on this Member Claim Form is true and correct. I authorize the release of any medical information necessary to process this claim.

Signature	Name	Date
X		

HOW TO USE THIS FORM

Dear Member:

Usually, all providers of health care will bill us for services to you and your enrolled dependents. This is the preferred procedure. You are not bothered with claim forms and we often need more details than are ordinarily provided on bills to patients.

Sometimes, a physician may not bill us or an ambulance company, for example, they may send the bill directly to you. In either instance, we have no way of knowing about your claim. This Member Claim Form was developed to notify us of any covered health service for which we have not already been billed. Please read the following instructions about how to report Health Care Services.

We are happy to serve you.

SECTION A. PATIENT INFORMATION

Use this section to identify the patient.

SECTION B. SUBSCRIBER INFORMATION (on Anthem Blue Cross card)

Use this section to identify the subscriber. Some of this information may be found on your Anthem Blue Cross card.

SECTION C. MEDICAL INFORMATION: This section pertains to the employee through whose employer your program is obtained

HEALTH CARE SERVICES: Use this section to report any COVERED health service that has not already been reported to this Anthem Blue Cross Plan by the provider of service (the physician, clinical, ambulance company, private duty nurse, etc.) **Attach itemized bill or photocopy.** Please be sure that duplicate bills are not submitted.

MEMBER CLAIM FORM INSTRUCTIONS:

For services rendered in California, please send claims to P.O. Box 60007, Los Angeles, CA 90060

For out-of-state claims, please contact Customer Service for the claims office address. Out-of-state claims must be sent to the Blue Plan of the state in which services were rendered. For your convenience, the Customer Service number is listed on your Member ID card.