Coast Colleges

MEDICAL CLAIM FORM

DELTA HEALTH SYSTEMS

MAIL THIS FORM TO: ANTHEM BLUE CROSS HOST UNIT
P.O. BOX 60007, LOS ANGELES, CA 90060-0007

EMPLOYEE ID # DLU 792-____ ____ ____ ____ ____ D **JAA CASE #DLU277424**

PATIENT AND EMPLOYEE INFORMATION

1. PATIENT'S NAME	2. PATIENT'S DATE OF BIRTH	3. EMPLOYEE'S NAME
4. PATIENT'S ADDRESS (STREET, CITY, STATE, ZIP CODE)	5. PATIENT'S SEX ☐ MALE ☐ FEMALE 7. PATIENT'S RELATIONSHIP TO EMPLOYEE ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER	6. EMPLOYEE'S ADDRESS (STREET, CITY, STATE, ZIP CODE) ☐ CHECK HERE IF NEW ADDRESS

8. OTHER HEALTH INSURANCE COVERAGE
IS PATIENT COVERED BY ANY OTHER PLAN? ☐ YES ☐ NO IF YES, PROVIDE NAME AND ADDRESS OF CARRIER:

IDENTIFICATION NUMBER _____ NAME OF EMPLOYER _____

TYPES OF COVERAGE BY CARRIER: ☐ MEDICAL ☐ DRUG ☐ DENTAL ☐ VISION

EFFECTIVE DATE OF COVERAGE _____ TERMINATION DATE OF COVERAGE _____

9. I AUTHORIZE THE UNDERSIGNED PHYSICIAN TO RELEASE ANY INFORMATION ACQUIRED IN THE COURSE OF MY EXAMINATION OR TREATMENT.	10. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICE(S) DESCRIBED BELOW.
SIGNED (EMPLOYEE OR PATIENT) _____ DATE _____	SIGNED (EMPLOYEE OR PATIENT) _____ DATE _____

PHYSICIAN OR SUPPLIER INFORMATION

11. DATE OF ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)	12. DATE FIRST CONSULTED YOU FOR THIS CONDITION	13. WAS CONDITION RELATED TO: PATIENT'S EMPLOYMENT ☐ YES ☐ NO

14. WAS CONDITION RELATED TO ACCIDENT? ☐ YES ☐ NO IF ACCIDENT RELATED, PLEASE GIVE DETAILS:

15. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE AND ADDRESS	16. FOR SERVICES RELATED TO HOSPITALIZATION, GIVE HOSPITALIZATION DATES ADMITTED _____ DISCHARGED _____
17. NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED	18. WAS LAB WORK PERFORMED OUTSIDE YOUR OFFICE? ☐ YES ☐ NO CHARGES

19. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D

PLACE OF SERVICE CODES*

1 - INPATIENT HOSPITAL	6 - NIGHT CARE FACILITY(PSY)	B - AMB SURG CTR
2 - OUTPATIENT HOSPITAL	7 - NURSING CARE	C - RESID TREAT CTR
3 - DOCTOR'S OFFICE	8 - SKILLED NURSING FAC	D - SPECIALIZED TREAT CTR
4 - PATIENT'S HOME	9 - AMBULANCE	E - COMP O/P REHAB
5 - DAY CARE FACILITY(PSY)	O - OTHER LOCATION	F - IND KIDNEY DISEASE TREAT CTR
	A - INDEPENDENT LAB	

20. A DATE OF SERVICE FROM	TO	B* PLACE OF SERVICE	C FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN CPT-4 PROCEDURE CODE	(EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)	D DIAGNOSIS CODE	E CHARGES	F DAYS OR UNITS

21. SIGNATURE OF PHYSICIAN OR SUPPLIER (INCLUDING DEGREE(S) OR CREDENTIALS) DATE	22. ACCEPT ASSIGNMENT (GOVERNMENT CLAIMS ONLY) ☐ YES ☐ NO	23. TOTAL CHARGES	BALANCE DUE
	24. YOUR TAX IDENTIFICATION NUMBER	25. PHYSICIAN'S, SUPPLIER'S, AND/OR GROUP NAME, ADDRESS, ZIP CODE AND TELEPHONE NUMBER	
26. YOUR PATIENT'S ACCOUNT NUMBER	27. TAXABLE ENTITY NAME (IF DIFFERENT THAN BOX 25)		

57055 K P CORPORATION MEDICAL SYSTEMS