

**ITEMIZED BILLS FOR COVERED SERVICES OR SUPPLIES
MUST BE ATTACHED AND THE ITEMIZED BILLS MUST CONTAIN:**

NAME OF THE PERSON OR ORGANIZATION PROVIDING THE SERVICES OR SUPPLIES
 NAME OF THE PATIENT RECEIVING THE SERVICES OR SUPPLIES
 EACH DATE THE SERVICES OR SUPPLIES WERE PROVIDED
 EACH CHARGE FOR THE SERVICES OR SUPPLIES
 DESCRIPTION OF THE SERVICES OR SUPPLIES

IN ADDITION

BILLS FOR SPECIAL NURSING SERVICE MUST SHOW THE PROFESSIONAL STATUS OF THE NURSE, SUCH AS R.N. (REGISTERED NURSE) AND REGISTRATION NUMBER (INCLUDE SHIFT(S) WORKED AND DATE(S))

BILLS FOR PRESCRIPTION DRUGS MUST SHOW THE PRESCRIPTION NUMBERS FOR EACH DRUG

ITEMIZED BILLS CANNOT BE RETURNED

EXAMPLE OF ITEMIZED BILL:

	Dayton Penridge, M.D. 101 Fourth Street Healthville, U.S.A.	Name of person Providing Service
	Joseph Warowes 102 West 35th Street Healthville, U.S.A.	
Name of Patient	For Professional Services Rendered To: Virginia E. Warowes	
Date each service was provided	5/1/67 Office Care Blood Test 5/2/67 Examination at Home 5 /6/67 Electrocardiogram in Office	\$ XXX XXX XXX XXX
	Explanation of each service	Charge for each service

This Completed Form, Together With the Itemized Bill And Supporting Material
May Be Submitted To:

BLUE CROSS AND BLUE SHIELD OF FLORIDA, INC.

P.O. Box 1798 - 532 Riverside Avenue
 Jacksonville, Florida 32231-0014

“Any person who knowingly and with intent to injure, defraud, or deceive any insurance company files a statement of claim containing any false, incomplete or misleading information is guilty of a felony of the third degree.”

Florida Statutes, Section 817.234



DO NOT WRITE IN THIS BLOCK



P. O. Box 1798
532 Riverside Avenue
Jacksonville, Florida 32231-0014

Please refer to your identification card for your toll-free customer service telephone number.

MAJOR MEDICAL/COMPREHENSIVE CLAIM FORM

PART I COMPLETE

PATIENT'S LAST NAME FIRST MI CONTRACT NUMBER SEX DATE OF BIRTH
M F mo. day yr.

RELATIONS OF PATIENT TO SUBSCRIBER
Subscriber (SUB) Spouse (SPO) Son (SON)
Daughter (DAU) Handicapped Dependent (HDP) Sponsored Dependent (SDP) Other (OTH)

Is patient dependent and a full time student at an accredited college or university?
Was condition related to:
A. Auto Accident? Date -
B. Patients employment?

Subscriber's name and address (include zip code) permanent address?
Patients place of employment - Name and address (include zip code)
Subscriber's place of employment - Name and address (include zip code)

IF THERE IS ANY INSURANCE OTHER THAN YOUR BASIC BLUE CROSS AND BLUE SHIELD APPLICABLE TO THE EXPENSES AND SERVICES CONNECTED WITH THIS ILLNESS CHECK YES AND COMPLETE INFORMATION

IS INSURANCE OBTAINED THROUGH EMPLOYER? POLICY NUMBER EFFECTIVE DATE Name and address of insurance company (include zip code)
NAME OF INSURED TYPE COVERAGE
Single Family

HAS OTHER INSURANCE PAID? (IF YES INCLUDE COPY OF SUMMARY OF BENEFITS)

PLEASE INDICATE NATURE OF ILLNESS (ES) AND NAME OF PHYSICIAN(S)

NATURE OF ILLNESS IF ACCIDENT GIVE DATE NAME OF PHYSICIAN (SIGNATURE NOT REQUIRED)

SUBSCRIBERS Certification: I certify that all information provided on this form and on the attached itemized statement are true and correct to the best of my knowledge.
Subscriber's Signature Date Telephone Number Area Code -

PART II COMPLETE FOR ASSIGNMENT OF PAYMENT ONLY

ASSIGNMENT OF BENEFITS: I authorize payment of benefits to the undersigned physician, hospital or supplier of service described above.
NAME AND ADDRESS (INCLUDE ZIP CODE) OF:
Physician Hospital Supplier

SUBSCRIBER'S SIGNATURE

4240-1193R SR