

An **itemized bill** is a form the provider uses that details the services received by the member and the cost of each service. It is not a statement which shows only the balance due. Please do not highlight or modify receipts as this may cause delayed processing of your claim.

Complete a separate claim form for each provider of service, such as doctor or laboratory.

Please do not use for more than one provider or patient.

4. FOR DENTAL CLAIM (ITEMIZED BILL MUST BE ATTACHED)

A. Was the treatment for orthodontic care? No Yes

B. Did treatment include an artificial device(s) such as dentures, bridge(s), crown(s), etc.? No Yes

If "Yes," was the treatment to replace an existing artificial device? _____

If "Yes," please explain why the replacement was necessary and give the date (if known) of the last replacement. _____

5. FOR VISION CLAIM (ITEMIZED BILL MUST BE ATTACHED)

If lenses were prescribed, what type? Single Bifocal Trifocal Contact Other (please specify) _____

6. FOR ALL OTHER CLAIMS — DOCTOR, CLINIC, LAB, ETC. (ITEMIZED BILL MUST BE ATTACHED)

What was the condition requiring treatment? (Diagnosis)

Check here if routine physical examination

Is the condition work related? No Yes

Has the patient or will the patient file a workers' compensation claim? No Yes

Is this a second surgical opinion? No Yes

Is this a third surgical opinion? No Yes

Surgical procedure _____

ACCIDENT INFORMATION

Was the reason for treatment due to an accident? No Yes

Where did the accident occur?

At work At home Auto Other _____

What was the exact date of the accident/injury? _____ / _____ / _____
(Month / Day / Year)

If auto accident, do you have:

Personal injury protection? No Yes

Uninsured or underinsured coverage? No Yes

Medical payment coverage? No Yes

Name and address of auto insurance company:

Do you intend to make a claim against a third party? No Yes

A person who knowingly and with intent to injure, defraud or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

X

Patient's signature (or legal guardian if patient cannot legally consent to services)

Date (Month/Day/Year)

To be accepted, this form must be fully completed (as applicable to the claim being submitted), signed, and have proper bills attached.

Mail to: Premera Blue Cross
P.O. Box 91059
Seattle, WA 98111-9159