



DO NOT WRITE IN THIS BLOCK

MAJOR MEDICAL/COMPREHENSIVE CLAIM FORM

BlueCross BlueShield of Florida

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.

Blue Cross and Blue Shield						1011-1100	2001011101 00	Tioo tolopi		
PART I			СО	MPLE	TE					
PATIENT'S LAST NAME		FIRST MI		CON	CONTRACT NUMBER			DAT	OF BI	RTH
							M F	mo	. day	yr.
	RELATION	SHIP OF PATIENT TO SUB	SCRIBER		WAS CONDITION	RELATED TO):	1110	. doy	у
Subscriber	(SUB)	☐ Daughter	(DAU)			o Accident? [Yes	□ No	
☐ Spouse	(SPO)	☐ Handicapped Deper				ent's Employe			☐ No	
☐ Son	(SON)	☐ Sponsored Depende								_
		Other	(OTH)							
Is patient dep university? \ and address (in	Yes 🗌 No l				Subscriber's name address? Yes		nclude zip c	ode) perma	nent	
Patient's place o	of employmen	t - Name and address (includ	e zip code)		Subscriber's place of	employment ·	- Name and a	address (inc	lude zip o	ode)
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		RANCE OTHER THAN CTED WITH THIS ILLN							No 🗆	ISES
IS INSURANCE			EFFECTIVE DA		Name and address of					
THROUGH EM		POLICY NOWIDEN	EFFECTIVE D	-11	Name and address of	i ilisarance cor	mpany (men	ude zip cou	c/.	
NAME OF INS	URED		TYPE COVER	AGE						
			Single Family							
HAS OTHER	INSURANC	CEPAID? Yes 🗆 N	lo 🗆 (IF YE	SINC	LUDE COPY OF SI	UMMARY O	F BENEF	ITS)		
	PLEAS	E INDICATE NATU	RE OF ILLNE	SS(E	S) AND NAME	OF PHYS	ICIAN(S	3)		
NATURE OF		IF ACCIDENT			NAME OF PHY				UIRED)	
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								T .		
Subscriber's Certification: I certify that all information provided on this form and on the attached itemized statements are true					nature		Date	Te	lephone N	Numbe
and correct to t								A	ea Code -	
PART II		COMPLET	TE FOR ASSIG	NME	NT OF PAYMEN	TONLY				
		authorize payment of benefits			NAME AND AD	DRESS (INC.)	LIDE ZID O	ODE! OF:		
cian, hospital or supplier of service described above. If none of the blocks are checked and the name of the physician, hospital or supplier does not appear, payment will be made to the subscriber except in those cases where the provider rendering the service maintains participating or contracting status with Blue Cross and Blue Shield of Florida, Inc. In such cases, payment will go directly to the provider unless there is an indication that the bill has been paid in full.					NAME AND AD Physician	Hospit			upplier [

SUBSCRIBER'S SIGNATURE

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

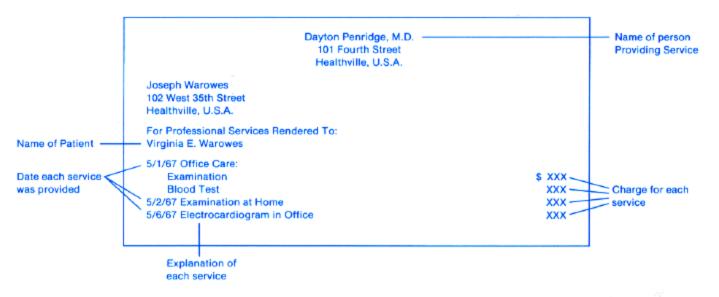
IN ADDITION

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:



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