Blue Cross and Blue Shield of New Mexico

P.O. Box 27630
Albuquerque, New Mexico 87125-7630

Office Use Only

Standard Claim Form

One patient per claim form. Please print and complete all sections of form. One provider per claim form except for prescription drugs.

Patient Name: Last ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ First ☐☐☐☐☐☐☐☐☐☐ Middle Initial ☐

Date of Birth: Month ☐☐ Day ☐☐ Year ☐☐ Sex M ☐ F ☐

Relationship to Member: Self ☐ Spouse ☐ Child ☐ Other ☐

Blue Cross and Blue Shield Identification Number:
(Refer to ID Card) ☐☐☐☐☐☐☐☐☐☐☐☐

Blue Cross and Blue Shield Group Number:
(Refer to ID Card) ☐☐☐☐☐☐☐☐

Employee/Cardholder name (Last, First, Middle Initial):

Diagnosis (Symptoms/Illness/Complaint/Injury) – briefly describe:

Current Address (Street, City, State, Zip Code):

If an accident, date of accident: _______________

Describe accident:

If you have moved within the past 6 months, please give your former address:

Telephone number where you can be reached (between 9 a.m. and 5 p.m.):

COORDINATION OF BENEFITS INFORMATION – PLEASE ANSWER ALL QUESTIONS

Were these services required as a result of a job-related illness or accident? Yes ❑ No ❑
If yes, date of illness or injury:____________________________

Name and address of employer:

Name and address of workers' compensation carrier:

Were these services required due to an accident or injury caused by another party? Yes ❑ No ❑
Automobile accident? Yes ❑ No ❑

Name and address of automobile insurance company:

Is patient covered by any other health benefit plan? Yes ❑ No ❑
Name and address of insurance company:

Name of policyholder:

Is patient eligible for Part A and/or Part B of Medicare?
Part A Yes ❑ No ❑ Effective Date:________________
Part B Yes ❑ No ❑ Effective Date:________________

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Do you want more claim forms? Yes ❑ No ❑

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Submitted by:

____ ___________________________
Signature Date

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→ SEE FILING INSTRUCTIONS ON REVERSE SIDE.

Claim Filing Instructions

To avoid delays or a return of your claim, please be certain that the itemized bill contains the following information:

- **Patient's** name
- **Patient's** date of birth
- Provider's name and address
- Date of service **(month, day, and year)**
- Type of service received
- Charge for each service rendered
- Diagnosis

REMEMBER: Canceled checks, cash register receipts, personal itemizations, and balance due or paid on accounts statements are not acceptable substitutes for itemized statements.

This Standard Claim Form is to be used for the filing of all fully insured, administrative services only, and third-party administrative account claims.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.