



Blue Cross BlueShield of Florida

An Independent Licensee of the Blue Cross and Blue Shield Association

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

DO NOT WRITE IN THIS BLOCK

MAJOR MEDICAL/COMPREHENSIVE CLAIM FORM

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

PART I COMPLETE

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

RELATIONSHIP OF PATIENT TO SUBSCRIBER
Subscriber (SUB) Spouse (SPO) Son (SON)
Daughter (DAU) Handicapped Dependent (HDP) Sponsored Dependent (SDP) Other (OTH)
WAS CONDITION RELATED TO:
A. Auto Accident? Date - Yes No
B. Patient's Employment? Yes No

Is patient dependent and a full time student at an accredited college or university? Yes No
If yes, enter college/university name and address (include zip code)
Subscriber's name and address (include zip code) permanent address? Yes No

Patient's 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 BELOW Yes No

IS INSURANCE OBTAINED THROUGH EMPLOYER? POLICY NUMBER EFFECTIVE DATE Name and address of insurance company (include zip code).
Yes No
NAME OF INSURED TYPE COVERAGE
Single Family

HAS OTHER INSURANCE PAID? Yes No (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)

Subscriber's Certification: I certify that all information provided on this form and on the attached itemized statements 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. 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.
SUBSCRIBER'S SIGNATURE
NAME AND ADDRESS (INCLUDE ZIP CODE) OF:
Physician Hospital Supplier

4240-596R SR