An Independent Licensee of the Blue Cross and Blue Shield Association.

mm dd yyyy

( )

Policy Effective Date mm dd yyyy

9. Was condition related to: a. Patient's Employment ❒

11. Ordering Physician

Phone: ( )

Address City State ZIPkeep

e the bill (see contains back all of **Sign** requiretbrm **this** infoftnatfform. required in

e undersigned, furnished the above information to enable Blue Cross and Blue Shield of Alabama to consider this claim payment, and I certify that such information is true and correct and that the expenses were incurred by the above named ent. **I understand that any payment will be made to me.**

ature Date

SEE BACK OF CLAIM FORM FOR EASY CLAIM FILING INSTRUCTIONS