HEALTH INSURANCE CLAIM FORM Send Completed Claim Form To: Blue Cross and Blue Shield of Illinois P.O. Box 805107 CHICAGO, IL 60680-4112

PLEASE PRINT OR TYPE CLEARLY

NOTICE TO ALL PARTIES COMPLETING THIS FORM: It is fraudulent to fill out this form with information you know to be false or to omit important facts. Criminal and/or civil penalties can result from such acts.

ID NUMBER Copy this from ye	our Blue Cross and Blue Shield k	dentification Card.			***************************************		
GROUP NUMBER:		IDENTIFIC	ATION NUMB	ER: (Include 3-digit alpha	a prefix)		***************************************
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IF CLAIM IS FOR CHILD 19 OR O	ILDER - IS CHILD:	A full time stude	nt? DY	es 🗆 No	Handicap	xped?	Yes 🗆
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IF COVERAGE IS THRU GROUP (EMPLOYER) NAME: YOUR EMPLOYER, PROVIDE					WORK PH	*	
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☐ Yes (provide below) ☐ No POLICY HOLDER NAME:				T FOO	INI CECHOMY	N aromo.	
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surance company, or oth	er person or firm to prov	ide Blue Cross	and Blue S	hield information.	includina c	onies or rec	in agency cords
ncerning advice, care or	treatment provided the	patient above ir	icluding, w	ithout limitation. i	nformation	relating to n	nental illn
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