WELS VEBA Vision and Flu Shot Claims

1. All claims for routine vision and flu shots should be sent by the member directly to Anthem Blue Cross Blue Shield for processing.

2. Claims should be sent to: Anthem BCBS
   PO Box 166
   Indianapolis, IN 46206
   Mailpoint: IN0204-D486

3. A designated processor has been assigned to process routine vision and flu shot claims.

4. The claim forms are customized specifically for WELS VEBA routine vision and flu shot claims. They are not to be used for any other services.

5. Once processing is completed, an explanation of benefits along with a check for payment to the member will be sent.

To ensure timely processing of your vision and flu shot claims, please be sure to complete Item #1 – "Number" on the claim form by entering the ID Number listed on the front of your ID card.

If you have any questions regarding submitting these claims or other benefit questions, please contact Anthem BCBS customer service at 1-877-512-7875 during normal customer service hours from 7AM to 7PM Central Time, Monday through Friday.

WELS VEBA
VISION AND FLU SHOT FORM
Mail To:
Anthem Blue Cross and Blue Shield
PO Box 166
Indianapolis, IN 46206
ATTN: Mailpoint IN0204-D486

Anthem

Subscriber Submitted Claim

* 1. IDENTIFICATION NUMBER	2. GROUP NUMBER	3. PATIENT NAME (Last, First, Initial) *(PLEASE PRINT)*	4. PATIENT BIRTHDATE MO. / DAY / YR.
	003325100		

5. PATIENT SEX	6. PATIENT RELATIONSHIP TO SUBSCRIBER	7. SUBSCRIBER NAME (Last, First, Initial)
☐ MALE ☐ FEMALE	☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER	

8. SUBSCRIBER ADDRESS (Street, City, State, Zip Code)

COORDINATION OF BENEFITS INFORMATION – ANSWER "YES" OR "NO" TO ALL QUESTIONS

9. IF NO GO TO QUESTION 10 WERE THESE SERVICES REQUIRED AS A RESULT OF A JOB-RELATED ILLNESS OR ACCIDENT? ☐ YES ☐ NO	9a. NAME AND ADDRESS OF EMPLOYER	9b. NAME AND ADDRESS OF COMPENSATION CARRIER	9c. DATE OF ACCIDENT
10. IF NO GO TO QUESTION 11 WERE SERVICES REQUIRED FOR A CONDITION RESULTING FROM AN ACCIDENT OR INJURY CAUSED BY ANOTHER PARTY? ☐ YES ☐ NO			10a. DATE OF ACCIDENT OR INJURY
11. IF NO GO TO QUESTION 12 IS PATIENT COVERED BY ANY OTHER GROUP HEALTH BENEFIT PLAN? ☐ YES ☐ NO	11a. NAME OF POLICYHOLDER	11b. NAME AND ADDRESS OF INSURANCE COMPANY	11c. POLICY NUMBER
12. IF NO GO TO QUESTION 13 WERE SERVICES REQUIRED DUE TO AN AUTOMOBILE ACCIDENT? ☐ YES ☐ NO	12a. NAME AND ADDRESS OF AUTOMOBILE INSURANCE COMPANY		12b. DATE OF ACCIDENT
13. IF NO GO TO QUESTION 14 IS PATIENT ELIGIBLE FOR PART A AND/OR PART B MEDICARE?	PART A ☐ YES ☐ NO PART B ☐ YES ☐ NO		13a. MEDICARE NUMBER

14. ILLNESS OR SYMPTOMS – FOR REIMBURSEMENT

15. NAME OF PROVIDER OR HOSPITAL FACILITY OF SERVICE	16. IF PLACE OF SERVICE WAS OUTPATIENT HOSPITAL, PROVIDE NAME OF HOSPITAL FACILITY
18. IF WE HAVE QUESTIONS, WHO MAY WE CONTACT? Name: _____ Phone No. _____	

PLEASE COMPLETE THE FOLLOWING AS A SUMMARY OF THE ITEMIZED BILLS YOU HAVE ATTACHED TO THIS CLAIM FORM

19. DATE OF SERVICE	20. PLACE OF SERVICE*	21. CHARGE FOR SERVICE	22. BRIEFLY DESCRIBE THE SERVICE(S) YOU RECEIVED

23. TOTAL CHARGES FOR WHICH YOU ARE REQUESTING CONSIDERATION OF PAYMENT $ _____	* PLACE OF SERVICE O - OFFICE H - HOME	OP - OUTPATIENT HOSPITAL NH - NURSING HOME	IP - INPATIENT HOSPITAL P - PHARMACY	L - LAB

24. I CERTIFY TO THE ACCURACY AND COMPLETENESS OF ALL INFORMATION REPORTED BY ME ON THIS FORM AND AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM.

SIGNATURE DATE

FULL SIGNATURE AND DATE
REQUIRED ON EACH FORM
INCOMPLETE FORMS MAY DELAY PROCESSING. PLEASE ENSURE ALL FIELDS ARE ANSWERED

4297 (REV. 7/04)