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**How to file:**

Related medical claim must be on file before Anthem will reimburse for Travel and Lodging.

Member must include the qualifying medical claim date of service and/or claim number or attach a copy of their qualifying claim's Explanation of Benefits.

The Member is responsible for the payment of services rendered.

A valid receipt must be submitted for the expenses. All receipts must be itemized and legible. Itemization includes, but is not limited to, name, date, time, amounts, and purpose. Credit card slips are not acceptable as documentation.

Keep a duplicate copy of your itemized bills as they will not be returned to you. This claim may be returned to you if all required information is not present.

It is required that all blocks and fields are completed. Use a separate line for each date of service and receipt.

Briefly indicate the type of service, i.e., travel, etc. For travel by car list number of miles from permanent residence to treating facility.

Your signature attests to the accuracy and completeness of all information on the claim form (including the receipts). It also authorizes the release of your medical records by the provider to our office if necessary.

We encourage you to file claims within 90 days of the service date. Please refer to your Description of Benefits for specific timely filing limitations and any applicable limitations and exclusions.

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**Please remit photocopies of your itemized receipts, completed claim form and any supporting documentation to:**

**Anthem_MTL_Member_Submit_Claim_Mailbox@anthem.com**

Or click the link below

**Anthem_MTL_Member_Submit_Claim_Mailbox@anthem.com**

**PLEASE NOTE: Submission of this form outside the above email address (via Member Portal, USPS mailbox address, etc.) may delay processing.**

If you have questions or need assistance, please contact the number indicated on the back of your ID card.

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# ONE PATIENT PER CLAIM FORM

| IDENTIFICATION NUMBER: | GROUP NUMBER: | PATIENT NAME (LAST, FIRST, INITIAL)(*PLEASE PRINT*) | PATIENT BIRTHDATE: MO DAY YR |
|---|---|---|---|
| | | | |

| PATIENT RELATIONSHIP TO SUBSCRIBER: ☐ Self ☐ Spouse ☐ Child ☐ Other | SUBSCRIBER NAME: |
|---|---|

IF WE HAVE QUESTIONS, WHO MAY WE CONTACT?

Name: _____ Address: _____ Phone: _____

| I Attest that this was the closest available Participating provider to my residence that performs the services I needed ☐ | Qualifying claim date of service: | |
|---|---|---|
| | Qualifying claim number (not required): | |

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

| DATE OF SERVICE | TYPE OF SERVICE | CHARGE FOR SERVICE (OR MILES TRAVELED) | BRIEFLY DESCRIBE THE SERVICES YOU RECEIVED OR INCURRED |
|---|---|---|---|
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| **TOTAL CHARGES FOR** WHICH YOU ARE REQUESTING CONSIDERATION OF PAYMENT $_____ | **TYPE OF SERVICE:**<br>**T** – NUMBER OF MILES TRAVELED BY CAR<br>**A** – AIRFARE (OVER 300 MILES FROM RESIDENCE<br>**L** – LODGING<br>**M** – MEALS (***IF A COVERED BENEFIT***) |
|---|---|

**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.**

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