



An Independent Licensee of the Blue Cross and Blue Shield Association.
 P.O. Box 11968
 Albuquerque, New Mexico 87192-1968

Office Use Only

Standard Claim Form

Patient Name: Last <input type="text"/>										First <input type="text"/>					Middle Initial <input type="text"/>														
Date of Birth: Month <input type="text"/>										Day <input type="text"/>					Year <input type="text"/>														
Sex: M <input type="checkbox"/>										F <input type="checkbox"/>					Relationship to Member: Self <input type="checkbox"/>														
Spouse <input type="checkbox"/>										Child <input type="checkbox"/>					Other <input type="checkbox"/>														
HMO New Mexico Identification Number: (Refer to ID Card) <input type="text"/>										Diagnosis (Symptoms/Illness/Complaint/Injury) – briefly describe:																			
Employee/Cardholder name (Last, First, Middle Initial):															If an accident, date of accident: Describe accident:														
Current Address (Street, City, State, Zip Code):																													
If you have moved within the past 6 months, please give your former address:																													
Telephone number where you can be reached (between 9 a.m. and 5 p.m.):																													

COORDINATION OF BENEFITS INFORMATION – PLEASE ANSWER ALL QUESTIONS

Were these services required as a result of a job-related illness or accident? Yes <input type="checkbox"/> No <input type="checkbox"/>														
If yes, date of illness or injury: _____														
Name and address of employer:										Name and address of workers' compensation carrier:				
Were these services required due to an accident or injury caused by another party? Yes <input type="checkbox"/> No <input type="checkbox"/>														
Automobile accident? Yes <input type="checkbox"/> No <input type="checkbox"/> Name and address of automobile insurance company:														
Is patient covered by any other health benefit plan? Yes <input type="checkbox"/> No <input type="checkbox"/>														
Name and address of insurance company:										Name of policyholder:				
Is patient eligible for Part A and/or Part B of Medicare?														
Part A Yes <input type="checkbox"/> No <input type="checkbox"/>					Effective Date: _____									
Part B Yes <input type="checkbox"/> No <input type="checkbox"/>					Effective Date: _____									

File Promptly – Your time limit to file for Medical Service Reimbursement is six months after the service is provided.
 For prescription drugs you must fill out AdvancePCS claim form. If you have any questions, contact a HMO New Mexico Customer Service Representative toll-free at 800-423-1630.

Submitted by:

Signature

Date

→ SEE FILING INSTRUCTIONS ON REVERSE SIDE.

Claim Filing Instructions

To avoid delays or a return of your claim, please be certain that the itemized bill contains the following information:

- **Patient's** name
- **Patient's** date of birth
- Provider's name and address
- Date of service (**month, day, and year**)
- Type of service received
- Charge for each service rendered
- Diagnosis

REMEMBER: Canceled checks, cash register receipts, personal itemizations, and balance due or paid on accounts statements are not acceptable substitutes for itemized statements.

This Standard Claim Form is to be used for the filing of all fully insured, administrative services only, and third-party administrative account claims.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.