ITEMIZED BILLS FOR COVERED SERVICES OR SUPPLIES MUST BE ATTACHED AND THE ITEMIZED BILLS MUST CONTAIN:

NAME OF THE PERSON OR ORGANIZATION PROVIDING THE SERVICES OR SUPPLIES NAME OF THE PATIENT RECEIVING THE SERVICES OR SUPPLIES EACH DATE THE SERVICES OR SUPPLIES WERE PROVIDED EACH CHARGE FOR THE SERVICES OR SUPPLIES DESCRIPTION OF THE SERVICES OR SUPPLIES

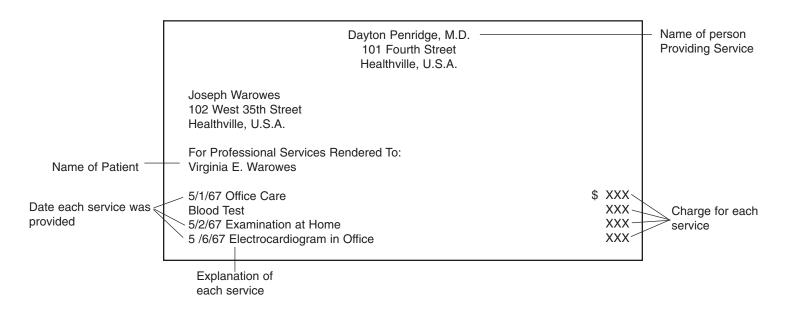
IN ADDITION

BILLS FOR SPECIAL NURSING SERVICE MUST SHOW THE PROFESSIONAL STATUS OF THE NURSE, SUCH AS R.N. (REGISTERED NURSE) AND REGISTRATION NUMBER (INCLUDE SHIFT(S) WORKED AND DATE(S))

BILLS FOR PRESCRIPTION DRUGS MUST SHOW THE PRESCRIPTION NUMBERS FOR EACH DRUG

ITEMIZED BILLS CANNOT BE RETURNED

EXAMPLE OF ITEMIZED BILL:



This Completed Form, Together With the Itemized Bill And Supporting Material May Be Submitted To:

BLUE CROSS AND BLUE SHIELD OF FLORIDA, INC.

P.O. Box 1798 - 532 Riverside Avenue Jacksonville, Florida 32231-0014

[&]quot;Any person who knowingly and with intent to injure, defraud, or deceive any insurance company files a statement of claim containing any false, incomplete or misleading information is guilty of a felony of the third degree."

P. O. Box 1798 532 Riverside Avenue Jacksonville, Florida 32231-0014

Please refer to your identification card for your **toll-free** customer service telephone number.

		Cross Shield
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PART I COMPLETE								
PATIENT'S LAST NAME	FIRST	MI	CONT	RACT NUMBER	SEX	DATE OF BIRTH		
					M F	mo. day yr.		
RELATION	NS OF PATIENT TO SUBSCI Daughter Handicapped De Sponsored Depe	(DAU) ependent (HDP)		WAS CONDITION RELATED A. Auto Accident? Date - B. Patients employment?	то:	Yes No Yes No		
Is patient dependent and a university? Yes \(\subseteq \text{No} \) No and address (include zip c	Subscriber's name and addres address? Yes \(\square\$	ss (include : No □	zip code) permanent					
Patients place of employment - Name and address (include zip code)			Subscriber's place of employment - Name and address (include zip code)					
IF THERE IS ANY INSURANCE OTHER THAN YOUR BASIC BLUE CROSS AND BLUE SHIELD APPLICABLE TO THE EXPENSES AND SERVICES CONNECTED WITH THIS ILLNESS CHECK YES AND COMPLETE INFORMATION Yes \square No \square								
IS INSURANCE OBTAINED THROUGH EMPLOYER? Yes No No	POLICY NUMBER	EFFECTIVE DA	ΤE	Name and address of insurance of	company (inc	clude zip code)		
NAME OF INSURED		TYPE COVERA Single ☐ Family ☐	GE					
HAS OTHER INSURANCE PAID? Yes No (IF YES INCLUDE COPY OF SUMMARY OF BENEFITS)								
PLE	ASE INDICATE NAT	URE OF ILL	IESS	(ES) AND NAME OF PH	IYSICIAN	(S)		
NATURE OF ILLNESS IF ACCIDENT GIVE DATE NAME OF PHYSICIAN (SIGNATURE NOT REQUIRED)								
					Г	1		
SUBSCRIBERS Certification: I certify that all information provided on this form and on the attached itemized statement are true and correct to the best of my knowledge.			Subscriber's Signature		Date	Telephone Number Area Code -		
PART II COMPLETE FOR ASSIGNMENT OF PAYMENT ONLY								
ASSIGNMENT OF BENEFITS: I authorize payment of benefits to the undersigned physician, hospital or supplier of service described above. If none of the blocks are checked and the name of the physician, hospital or supplier does not appear, payment will be made to the subscriber except in those cases where the provider rendering the service maintains participating contracting status with Blue Cross and Blue Shield of Florida, Inc. In such cases, payment will go directly to the provider unless there is an indication that the bill has been paid in full. SUBSCRIBER'S SIGNATURE								