Blue Cross BlueShield of Alabama

An Independent Licensee of the Blue Cross and Blue Shield Association.

mm dd yyyy

( )

Policy Effective Date mm dd yyyy

9. Was condition related to: a. Patient's Employment ☐

City State ZIPkeep

the bill (see ign required form **this** information **form.** required in

e undersigned, furnished the above information lue Shield of Alabama to consider this claim payment, and I certify that such information is tr the expenses were incurred by the above named ent. **I understand that any payment will be ma**

ature Date

SEE BACK OF CLAIM FORM FOR EASY CLAIM FILING INSTRUCTIONS

CL-438 (Rev. 11-2005)