

## MEDICAL CLAIM FORM

**YOUR CLAIM CANNOT BE PROCESSED UNLESS THIS FORM IS COMPLETE.**

Member ID Number: \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Group Number: \_\_\_\_\_  
*Last First M.I.*

Insured's Address: \_\_\_\_\_  
*Street City State Zip*

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Patient Birth Date: \_\_\_\_\_  
*Last First M.I.*

Relationship to Insured:     Insured                       Dependent  
    Spouse                               Other \_\_\_\_\_

Date of Service: \_\_\_\_\_ Provider: \_\_\_\_\_

Pay to Member             Pay to Provider (*must submit unassigned claim form from provider*)

**For member reimbursement attach:**

- Detailed Claim from Provider
- Proof of Payment

**Mail to:**

Baylor Scott & White Health Plan  
Attn: Pay Me  
1206 West Campus Drive  
Temple, TX 76502