



Anthem Blue Cross and Blue Shield
 P.O. Box 659806
 San Antonio, TX 78265-9106
 FAX: 800-848-2512

Request for List Bill Arrangement

IMPORTANT NOTE: An Individual application is required for each policy; a copy of this completed form must be attached to each application.

Bill To (Third Party Name): _____

List Bill Administrator: _____ Phone: _____ Fax: _____

Billing Address: _____

City, State, Zip: _____

Parent Group Account Number (For existing List Bill only): _____ Date: _____

_____	_____	_____	_____	<input type="checkbox"/> New <input type="checkbox"/> Change
Last Name	First Name	Middle Initial	Social Security Number	Type of Policy
<input type="checkbox"/> Kentucky <input type="checkbox"/> Indiana <input type="checkbox"/> Ohio	<input type="checkbox"/> Missouri		<input type="checkbox"/> Medicare Supplement	or <input type="checkbox"/> Individual

_____	_____	_____	_____	<input type="checkbox"/> New <input type="checkbox"/> Change
Last Name	First Name	Middle Initial	Social Security Number	Type of Policy
<input type="checkbox"/> Kentucky <input type="checkbox"/> Indiana <input type="checkbox"/> Ohio	<input type="checkbox"/> Missouri		<input type="checkbox"/> Medicare Supplement	or <input type="checkbox"/> Individual

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_____	_____	_____	_____	<input type="checkbox"/> New <input type="checkbox"/> Change
Last Name	First Name	Middle Initial	Social Security Number	Type of Policy
<input type="checkbox"/> Kentucky <input type="checkbox"/> Indiana <input type="checkbox"/> Ohio	<input type="checkbox"/> Missouri		<input type="checkbox"/> Medicare Supplement	or <input type="checkbox"/> Individual

Request for List Bill Arrangement (continued)

When and How to Use this Form

Please send this completed form to Anthem with all applications for List Bill accounts.

- Complete the top portion on the front of this form with the Third Party (person or organization to whom the List Bill will be sent for premium payment) name, address, phone number and List Bill Administrator's name.
- Include the List Bill Arrangement Parent Group number if you have an existing List Bill account (this number can be found on your monthly bill summary).
- List the name of each person whose application is being submitted with this form.
- Sign below (this form must be signed by the Third Party or List Bill Administrator).
- Check each application for completeness to avoid unnecessary delays.
- Attach a Permission to Provide List Bill Arrangement form to each application (this form must be signed by the applicant).
- Send only a copy of this form and a Permission to Provide List Bill Arrangement form when you are adding a person who has existing Anthem Individual coverage to your List Bill Arrangement (an application is not necessary unless they are requesting a change in their coverage).
- Keep a copy of the form for your file.

Mail or fax a copy of this form along with the Permission to Provide List Bill Arrangement form and the completed applications to:

Anthem Blue Cross and Blue Shield
P.O. Box 659806
San Antonio, TX 78265-9106
FAX: 800-848-2512

*Please don't hesitate to call your Anthem Bill Clerk at 800-713-5811 with List Bill Arrangement billing questions.

*Members should direct all other questions to Customer Service at the number on the back of their identification cards.

By signing this Request for List Bill Arrangement form, I certify that I understand the persons listed on this form have applied, or are applying for individual health coverage through Anthem Blue Cross and Blue Shield ("Anthem") and neither Anthem nor I intend for these individual health coverage policies to be employer sponsored health coverage. I certify that I do not contribute directly or indirectly through wage adjustments, reimbursement or otherwise to the premium of any employee or such employee's dependent on this List Bill Arrangement and I have not established a Section 125 Plan, Health Reimbursement Arrangement or any other arrangement allowing the payment of premiums with pre-tax dollars. I also certify that I have not represented to any person that the Anthem Individual health coverage policies that are billed to my address listed above in accordance with the terms set forth on this form are guaranteed issue or employer sponsored health coverage. I further acknowledge that Anthem has advised me to seek competent legal and tax guidance for compliance with applicable laws and regulations as they relate to a List Billing Arrangement.

Signature of Third Party or List Bill Administrator

Date

Anthem Blue Cross and Blue Shield is the trade name of: In Indiana: Anthem Insurance Companies, Inc. In Kentucky: Anthem Health Plans of Kentucky, Inc. In Ohio: Community Insurance Company. In Missouri (excluding 30 counties in the Kansas City area): RightCHOICE® Managed Care, Inc. (RIT), Healthy Alliance® Life Insurance Company (HALIC), and HMO Missouri, Inc. RIT and certain affiliates administer non-HMO benefits underwritten by HALIC and HMO benefits underwritten by HMO Missouri, Inc. RIT and certain affiliates only provide administrative services for self-funded plans and do not underwrite benefits. Independent licensees of the Blue Cross and Blue Shield Association. ®Anthem is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.