

# Subscriber's Statement of Claim

Send this claim to: Blue Shield of California, P.O. Box 272540, Chico, CA, 95927-2540.

This form is to be used only when the provider of service does not submit your claim directly to Blue Shield.

Check with the Provider to be sure no claim has been submitted.

Duplicate claims will not only be rejected but may delay payment of the original claim.

## Important instructions

- Use a separate form for:
  - A. Each member of the family
  - B. Each different provider of service
  - C. Each itemized bill
- Print or type
- Fill in all items completely
- Sign your name in the space provided

**Failure to comply with these instructions may result in your claim being delayed or returned to you.**

### Exceptions:

- Primary Medicare coverage
  - A. Submit claim to Medicare first.
  - B. Complete boxes 1 and 4 only.
  - C. Attach your explanation of Medicare benefits form and a copy of itemized services to this claim and send all to Blue Shield.
- Foreign claims
 

Any services rendered outside of the United States or its territories must include the US currency exchange rate or value and the translation for all billed services.

### 1

Subscriber name (Last, First, MI)		Subscriber number	Group number	
Mail address	City	State	ZIP	Is address new? <input type="checkbox"/> Yes <input type="checkbox"/> No

### 2

Patient's name	Date of birth (mo/day/yr)	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Relationship to subscriber <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child
----------------	---------------------------	--	---

Describe briefly patient's illness or injury and, if injury, how it occurred

Patient was treated for <input type="checkbox"/> Injury <input type="checkbox"/> Illness <input type="checkbox"/> Pregnancy	Date of injury, onset of illness or pregnancy	Is patient retired? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, effective date
--	---	---	------------------------

### 3

Does patient have other health coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, policy ID number	Name of insuring company	Effective date
Address of insuring company			Type of plan <input type="checkbox"/> Group <input type="checkbox"/> Individual
Name of policy holder	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of birth (mo/day/yr)	Name of employer

### 4

Was condition related to employment? <input type="checkbox"/> Yes <input type="checkbox"/> No	Does patient have Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, date of birth (mo/day/yr)	Part A effective date	Part B effective date
--	---	-----------------------------------	-----------------------	-----------------------

### Subscriber's signature

I certify that the foregoing information is accurate and complete, and authorize the release of any medical information necessary to process this claim.

X \_\_\_\_\_ Date \_\_\_\_\_