Blue Shield of California
An Independent Member of the Blue Shield Association

SUBSCRIBER'S STATEMENT OF CLAIM

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.

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SUBSCRIBER NAME (LAST NAME, FIRST, MI)	SUBSCRIBER NUMBER	GROUP NUMBER

MAIL ADDRESS — STREET	CITY	STATE	ZIP CODE	**IS ADDRESS NEW?**
				☐ YES ☐ NO

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NAME OF PATIENT (LAST NAME, FIRST NAME, MIDDLE INITIAL)	DATE OF BIRTH Month Day Year	PATIENT'S SEX	RELATIONSHIP TO SUBSCRIBER
		☐ Male ☐ Female	☐ Self ☐ Spouse ☐ Child

DESCRIBE BRIEFLY PATIENT'S ILLNESS OR INJURY AND, IF INJURY, HOW IT OCCURRED

PATIENT WAS TREATED FOR	DATE OF INJURY; ONSET OF ILLNESS OR PREGNANCY	IS PATIENT RETIRED?	If Yes:	EFFECTIVE DATE Month Day Year
☐ INJURY ☐ ILLNESS ☐ PREGNANCY		☐ YES ☐ NO		

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DOES PATIENT HAVE OTHER HEALTH COVERAGE? ☐ YES ☐ NO	IF YES, POLICY IDENTIFICATION NO.	NAME OF INSURING COMPANY	EFFECTIVE DATE

ADDRESS OF INSURING COMPANY	TYPE OF PLAN
	☐ GROUP ☐ INDIVIDUAL

NAME OF POLICY HOLDER	SEX	DATE OF BIRTH	NAME OF EMPLOYER

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WAS CONDITION RELATED TO EMPLOYMENT ☐ YES ☐ NO	DOES PATIENT HAVE **MEDICARE?** ☐ YES ☐ NO	If Yes:	PATIENT'S DATE OF BIRTH	**PART A** EFFECTIVE DATE Month Day Year	**PART B** EFFECTIVE DATE Month Day Year

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:** _____

SEND THIS CLAIM TO:
BLUE SHIELD OF CALIFORNIA
P.O. BOX 272540
CHICO, CA 95927-2540