



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:
 - EACH MEMBER OF THE FAMILY
 - EACH DIFFERENT PROVIDER OF SERVICE
 - 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 —
 - Submit claim to Medicare first.
 - Complete Boxes 1 and 4 only.
 - 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 NAME, FIRST, MI)		SUBSCRIBER NUMBER		GROUP NUMBER	
	MAIL ADDRESS — STREET	CITY	STATE	ZIP CODE	IS ADDRESS NEW? <input type="checkbox"/> YES <input type="checkbox"/> NO	

2	NAME OF PATIENT (LAST NAME, FIRST NAME, MIDDLE INITIAL)			DATE OF BIRTH Month Day Year			PATIENT'S SEX <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 Month Day Year	

3	DOES PATIENT HAVE OTHER HEALTH COVERAGE? <input type="checkbox"/> YES <input type="checkbox"/> NO		IF YES, POLICY IDENTIFICATION NO.		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			SEX	DATE OF BIRTH		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:	PATIENT'S DATE OF BIRTH Month Day Year			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