

SUBSCRIBER'S STATEMENT OF CLAIM

Send this claim to: American Specialty Health Plans of California, Inc., P.O. Box 509002, San Diego, CA, 92150 or appeals@ashn.com.

This form is to be used only when the out-of-network provider of service does not submit your claim directly to ASH Plans. 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 your family
 - Each different provider of service
 - Each itemized bill
- Please print or type.
- **Fill in all items completely.**
- Sign your name in the space provided.
- Not following these instructions may result in your claim being delayed or returned to you.

Please include a copy of your bill/claim that includes all of the following information:

- Date of service
- Charges for each individual procedure
- Diagnosis code(s)
- Procedure code(s)
- Place of treatment
- Provider name and address
- Provider tax ID

1	Subscriber name (Last name, First, M.I.)	Alpha prefix	Subscriber ID number	Group number	
	Mail address - Street	City	State	ZIP	Is address new? (Y/N)

2	Name of patient (Last name, First, M.I.)		Date of birth		Month	Day	Year
					/	/	/
	Patient's gender (M/F)	Relationship to subscriber (Self, Spouse/domestic partner, Child)					
	Describe briefly patient's illness or injury, and if injury, how it occurred						
	Patient was treated for (Injury, Illness, Pregnancy)	Date of injury, onset of illness, or pregnancy		Month	Day	Year	
				/	/	/	
Is patient retired? (Y/N)		If yes, coverage effective date		Month	Day	Year	
				/	/	/	

3	Does patient have other health coverage? (Y/N)		If yes, policy identification number				
	Name of insuring company		Effective date		Month	Day	Year
					/	/	/
	Address of insuring company		Type of plan (Group/Individual)				
Name of policy holder		Gender	Date of birth	Name of employer			

4	Was condition related to employment? (Y/N)		If yes, patient's date of birth		Month	Day	Year		
					/	/	/		
	Does patient have Medicare? (Y/N)	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 _____									

Please send this completed form to: ASH Plans, P.O. Box 509002, San Diego, CA, 92150 or appeals@ashn.com.

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