Subscriber Claim Form for Services Received Outside California

This form is used to submit claims directly to Blue Shield of California or Blue Shield of California Life & Health Insurance Company when you've received covered services outside of California. You should only use this form when you are certain that the provider of service has not and will not submit a claim for you. Duplicate claims will be rejected, and may delay payment of the claim if submitted by both you and your provider. If you have any questions about this form, call the Customer Service number on your Blue Shield ID card, or call **(877) 655-2583**.

Important instructions for subscriber submitted claims

- 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**
- **Provider tax ID**

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Subscriber name (Last name, First, M. I.)	Alpha prefix	Subscriber ID number		Group number	
Mail address – Street	City		State	ZIP	Is address new? ☐ Yes ☐ No

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Name of patient (Last name, First, MI)		Date of birth Month / Day / Year
Patient's gender ☐ Male ☐ Female	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? ☐ Yes ☐ No	If yes, coverage effective date	Month / Day / Year

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Does patient have other health coverage? ☐ Yes ☐ No	If yes, policy identification number		
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	If yes, patient's date of birth	
Does patient have Medicare? ☐ Yes ☐ No	Part A effective	Part B effective

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: Blue Shield of California, P.O. Box 1505, Red Bluff, CA 96080