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 clai	Important	instructions f	or subscriber	submitted	claim
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•	Use	a	separate	form	for
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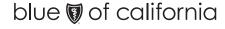
- Each member of your family
- Each different provider of service
- Each itemized bill
- Please print or type.
- Fill in all items completely.
- Sign your name in the space provided.
 Not following these instructions may result in your claim being delayed or returned to you.

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

- Date of service
- Charges for each individu
- Diagnosis code(s)
- Procedure code(s)
- Place of treatment
- Provider name
- Provider tax ID

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	Subscriber name (Last name, First, MI)	Alpha prefi	x Subscriber	ID numbe	er	Group r	number
	Mail address – Street	City	:		State	ZIP	ls address new? □Yes □ No
	Name of patient (Last name, First, MI)			Date of	birth I	Month/D	ay/Year
	Patient's gender Male Fem ale	Relationship	to subscriber	Self	□ Spou	use/dome	estic partner 🗌 Chilo
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 Month/Day/Year illness, or pregnancy					
	Is patient retired? Tes No		If yes, cover date	age effe	ctive	Month/[Day/Year
	Does patient have other health coverage	? Yes N	o If yes, pol	licy ident	ificatio	n number	
	Name of insuring company				Effect	ive da te	
3	Address of insuring company	Type of plan ☐ Group ☐ Individua					
	Name of policy holder	Sex	Date of birth	Name c	of empl	oyer	
	Was condition related to employment?	If yes, patient's date of birth					
	Does patient have Medicare? Yes No		Part A effective date			Part B effective date	
4	Subscriber's signature I certify that the foregoing information is information necessary to process this cla	d complete, c	and autho	orize th	e release	of any medical	
	Y				Dat	te.	

Please send this completed form to: Blue Shield of California, ATTN:Blue Card, P.O. Box 272630 Chico, CA 95927-2630



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