blue shield of california

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.

For your protection, California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Important instructions

- Use a separate form
  - 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 U.S. currency exchange rate or value and the translation for all billed services

1

Subscriber name (last, first, MI)	Subscriber number	Group number
Mail address (street, city, ZIP)	Is address new? ☐ Yes ☐ No	

2

Name of patient (last, first, MI)	Date of birth (month, day, year)
Relationship to subscriber ☐ Self ☐ Spouse ☐ Child ☐ Domestic partner	Patient's gender ☐ Male ☐ Female
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	Is patient retired? ☐ Yes ☐ No If yes, effective date?

3

Does patient have other health coverage? ☐ Yes ☐ No	If yes, part policy ID No.	Name of insuring company	Effective date
Address of insuring company		Type of plan ☐ Group ☐ Individual	

Name of policy holder	Gender ☐ Male ☐ Female	Date of birth	Name of employer

4

Was condition related to employment? ☐ Yes ☐ No	Does patient have Medicare? ☐ Yes ☐ No	If yes, Part A effective date	If yes, Part B effective date

Subscriber signature

For your protection, California law requires the following to appear on this form:

Important notice: Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in a state prison.

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 Life and Health Insurance Company, P.O. Box 272610, Chico, CA 95927-2610