American Specialty Health®

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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