CalPERS Supplement to Original Medicare Reimbursement Request Form

Email completed claim form and receipts to CalPERSClaims@blueshieldca.com. For assistance completing this form, call Blue Shield of California Customer Service at (800) 405-2127. This form is to be used only when the provider of service does not submit your claim directly to Blue Shield. Duplicate claims will not only be rejected but may delay payment of the original claim. Please check with the provider to be sure no claim has been submitted.

Important instructions

- Only applicable to CalPERS Gold and Platinum Supplement to Original Medicare PPO members.
- Use a separate form for:
  - Each member of the family.
  - Each different provider of service.
  - Each itemized bill.
- Print or type your responses in the spaces below and submit with receipts.
- Fill in all items completely. All fields are required.
- Sign your name in the space provided.
- **Errors on this form may result in your claim being delayed or denied.**

If you have primary Medicare coverage:

- Submit claim to Medicare first.
- Attach your Explanation of Medicare Benefits form and a copy of itemized services to this claim.
- 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.

Member/patient information

This service is for:

First name	Last name	
Member ID number	Date of birth	Gender ☐ Male ☐ Non-binary ☐ Female ☐ Other
Street address		Is address new? ☐ Yes ☐ No
City	State	ZIP code

Describe briefly patient's condition, illness, or injury and, if injury, how it occurred. Attach additional pages if needed.

Patient was treated for ☐ Injury ☐ Illness	Date of injury or onset of illness	Is patient retired? ☐ Yes ☐ No	If yes, effective date
Does patient also still work? ☐ Yes ☐ No	If yes, effective date	Employer name	

Employer address	Employer phone number	Was condition related to employment? ☐ Yes ☐ No

Member or legal guardian signature

I certify that the above information is accurate and complete, and authorize the release of any medical information necessary to process this claim.

Signature (written or typed)	Date
Print name	Relation to member