blue of california

Participant's Statement of Claim

Send this claim to: Blue Shield of California, P.O. Box 272540, Chico, CA, 95927-2540.
Questions? Call: 1 (888) 235-1767, Monday through Friday, 7 a.m. to 7 p.m., PT.

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.

Important instructions

- Use a separate form for:
  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.

Exeptions:

- 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 form and send all to Blue Shield.
- Foreign claims
  Any services rendered outside of the United States or its territories must include the US currency exchange rate or value and the translation for all billed services.

1

Participant name (Last, First, MI)		Participant number (see medical ID card)	Group number (see medical ID card)	
Mail address	City	State	ZIP Code	Is address new? ☐ Yes ☐ No

2

Patient's name	Date of birth (mo/day/yr)	Gender ☐ Male ☐ Female	Relationship to participant ☐ Self ☐ Spouse ☐ Child
Describe briefly patient's illness or injury and, if injury, how it occured			

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, policy ID number	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 (mo/day/yr)	Name of employer

4

Was condition related to employment? ☐ Yes ☐ No	Does patient have Medicare? ☐ Yes ☐ No	If Yes, date of birth (mo/day/yr)	Part A effective date	Part B effective date

Participant'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 _____