Subscriber's Statement of Claim

Send this claim to: Blue Shield of California, P.O. Box 272540, Chico, CA, 95927-2540. 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

To be complete:

- You must attach a copy of HCFA Form 1500 from the provider along with a receipt showing dollar amounts collected at the time services were rendered. If the provider is non-contracting and cannot provide a HCFA, please complete all fields in section 4.
- If the provider does not supply billing documents you must submit a receipt from the provider showing dollar amounts collected at the time services were rendered and complete all fields in section 4.

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 US currency exchange rate or value and the translation for all billed services.

Failure to comply with these instructions may result in your claim being delayed or returned to you.

1

Subscriber name (Last, First, MI)	Subscriber number UUE	Group number

Mail address	City	State	ZIP	Is address new? ☐ Yes ☐ No

2

Patient's name	Date of birth (mo/day/yr)	Gender ☐ Male ☐ Female	Relationship to subscriber ☐ 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

Date of service	Diagnosis code	Procedure code/Modifiers	Billed amount	Diagnosis
Date of service	Diagnosis code	Procedure code/Modifiers	Billed amount	Diagnosis
Date of service	Diagnosis code	Procedure code/Modifiers	Billed amount	Diagnosis
Date of service	Diagnosis code	Procedure code/Modifiers	Billed amount	Diagnosis

5

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

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 _____