

SUBSCRIBER'S STATEMENT OF CLAIM FORM

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.

GROUP NUMBER						PREFIX			SUBSCRIBER NUMBER														
SUBSCRIBER NAME:																							
ADDRESS:												CITY:						ST:			ZIP:		
PATIENT NAME:															DATE OF BIRTH:								
RELATION TO SUB: Self <input type="checkbox"/> Spouse <input type="checkbox"/> Other <input type="checkbox"/>															PATIENT'S SEX: M <input type="checkbox"/> F <input type="checkbox"/>								
OTHER INSURANCE COVERAGE: Yes <input type="checkbox"/> No <input type="checkbox"/>																							
MEDICARE COVERAGE PART A: Yes <input type="checkbox"/> No <input type="checkbox"/>															PART B: Yes <input type="checkbox"/> No <input type="checkbox"/>								
SUBSCRIBER 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: _____								

INSTRUCTIONS FOR SUBMITTING YOUR MEDICAL OR DENTAL CLAIM:

- Use a separate form for
 - (a) Each family member
 - (b) Each different provider of service
 - (c) Each itemized bill.
- If Medicare is primary coverage, submit claim to Medicare first. Attach your Explanation of Medicare Benefits form and a copy of the itemized claim and send all to Blue Shield.
- If you have a foreign claim, all claims from services rendered outside the United States or its territories must include the US currency exchange rate or value AND must be translated into English prior to claim submission.
- Submit your claim to:

Blue Shield of California
P.O. Box 272540
Chico, CA 95927-2540
800 - 535 - 8000