



## SUBSCRIBER'S STATEMENT OF CLAIM

**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.

**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.

<b>1</b>	SUBSCRIBER NAME (LAST NAME, FIRST, MI)		SUBSCRIBER NUMBER		GROUP NUMBER	
	MAIL ADDRESS — STREET		CITY	STATE	ZIP CODE	IS ADDRESS NEW? <input type="checkbox"/> YES <input type="checkbox"/> NO

<b>2</b>	NAME OF PATIENT (LAST NAME, FIRST NAME, MIDDLE INITIAL)			DATE OF BIRTH Month   Day   Year			PATIENT'S SEX <input type="checkbox"/> Male <input type="checkbox"/> Female		RELATIONSHIP TO SUBSCRIBER <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child			
	DESCRIBE BRIEFLY PATIENT'S ILLNESS OR INJURY AND, IF INJURY, HOW IT OCCURRED											
	PATIENT WAS TREATED FOR <input type="checkbox"/> INJURY <input type="checkbox"/> ILLNESS <input type="checkbox"/> PREGNANCY			DATE OF INJURY; ONSET OF ILLNESS OR PREGNANCY			IS PATIENT RETIRED? <input type="checkbox"/> YES <input type="checkbox"/> NO		If Yes:		EFFECTIVE DATE Month   Day   Year	

<b>3</b>	DOES PATIENT HAVE OTHER HEALTH COVERAGE? <input type="checkbox"/> YES <input type="checkbox"/> NO		IF YES, POLICY IDENTIFICATION NO.		NAME OF INSURING COMPANY				EFFECTIVE DATE		
	ADDRESS OF INSURING COMPANY							TYPE OF PLAN <input type="checkbox"/> GROUP <input type="checkbox"/> INDIVIDUAL			
	NAME OF POLICY HOLDER			SEX	DATE OF BIRTH	NAME OF EMPLOYER					

<b>4</b>	WAS CONDITION RELATED TO EMPLOYMENT <input type="checkbox"/> YES <input type="checkbox"/> NO		DOES PATIENT HAVE MEDICARE? <input type="checkbox"/> YES <input type="checkbox"/> NO		If Yes:		PATIENT'S DATE OF BIRTH Month   Day   Year			PART A EFFECTIVE DATE Month   Day   Year			PART B EFFECTIVE DATE Month   Day   Year		
	<p><b>SUBSCRIBER'S SIGNATURE</b></p> <p>I certify that the foregoing information is accurate and complete, and authorize the release of any medical information necessary to process this claim.</p> <p><b>X</b> _____ <b>DATE:</b> _____</p>														

**Blue Shield of California Life & Health Insurance Company**  
**SEND THIS CLAIM TO: P.O. Box 272610**  
**Chico, CA 95927-2610**