

**Mailing Address:**  
P. O. Box 272580, Chico, CA 95927-2580



**Blue Shield of California**  
An Independent Member of the Blue Shield Association

**BLUE SHIELD USE ONLY**

## SUBSCRIBER'S STATEMENT OF CLAIM - BLUE SHIELD EMPLOYEE

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:
    - EACH MEMBER OF THE FAMILY
    - EACH DIFFERENT PROVIDER OF SERVICE
    - 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 —
  - Submit claim to Medicare first.
  - Complete Boxes 1 and 4 only.
  - 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			PART A EFFECTIVE DATE Month   Day   Year			PART B EFFECTIVE DATE Month   Day   Year			
	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.										<b>*NEED ADDITIONAL CLAIM FORMS?</b> IN CALIFORNIA: 1-800-443-5005 OUT OF CALIFORNIA: 1-209-367-2800					
	X _____					DATE: _____										

**REQUEST CLAIM INFORMATION FROM:** Customer Service  
BLUE SHIELD OF CALIFORNIA  
P.O. Box 272580  
Chico, CA 95927-2580

**SEND THIS CLAIM TO:** BLUE SHIELD OF CALIFORNIA  
P.O. Box 272580  
Chico, CA 95927-2580