Subscriber claim form for services received outside California

This form is used to submit claims directly to Blue Shield of California or Blue Shield of California Life & Health Insurance company when you've received covered services outside of California. You should only use this form when you are certain that the provider of service has not and will not submit a claim for you. Duplicate claims will be rejected, and may delay payment of the claim if submitted by both you and your provider. If you have any questions about this form, call the Customer Service number on your Blue Shield ID card, or call **(877) 655-2583**.

Important instructions for subscriber submitted claims

- Use a separate form for:
  A. Each member of your 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

Not following these instructions may result in your claim being delayed or returned to you.

Please include a copy of your bill/claim that includes all of the following information:

- **Date of service**
- **Charges for each individual procedure**
- **Diagnosis code(s)**
- **Procedure code(s)**
- **Place of treatment**
- **Provider name**
- **Provider tax ID**

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Subscriber name (Last name, first, MI)				Alpha prefix
Subscriber ID number	Group number			
Mail address – Street	City	State	ZIP	Is address new? ☐ Yes ☐ No

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Name of patient (Last name, first, MI)	Date of birth (mm/dd/yyyy)
Patient's gender ☐ Male ☐ Female	Relationship to subscriber ☐ Self ☐ Spouse/domestic partner ☐ Child
Describe briefly patient's illness or injury, and if injury, how it occurred:	
Patient was treated for ☐ Injury ☐ Illness ☐ Pregnancy	Date of injury, onset of illness, or pregnancy (mm/dd/yyyy)
Is patient retired? ☐ Yes ☐ No	If yes, effective date (mm/dd/yyyy)

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Does patient have other health coverage? ☐ Yes ☐ No				If yes, policy ID number
Name of insuring company				Effective date
Address of insuring company	City	State	ZIP	Type of plan ☐ Group ☐ Individual
Name of policy holder	Gender ☐ Male ☐ Female	Date of birth	Name of employer	

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Was condition related to employment? ☐ Yes ☐ No	If yes, patient's date of birth
Does patient have Medicare? ☐ Yes ☐ No	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.

For your protection, California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Date _____

Please send this completed form to:
Blue Shield of California, Attn: BlueCard, P.O. Box 272630, Chico, CA 95927-2630