

# 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:
  - Each member of your family
  - Each different provider of service
  - Each itemized bill
- Please 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**

1	Subscriber name (Last name, First, MI)	Alpha prefix	Subscriber ID number	Group number
	Mail address – Street	City	State	ZIP
				Is address new? <input type="checkbox"/> Yes <input type="checkbox"/> No

2	Name of patient (Last name, First, MI)	Date of birth	Month	Day	Year
			/	/	
	Patient's gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Relationship to subscriber <input type="checkbox"/> Self <input type="checkbox"/> Spouse/domestic partner <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	Month	Day	Year
			/	/	
	Is patient retired? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, coverage effective date	Month	Day	Year
			/	/	

3	Does patient have other health coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, policy identification number			
	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	

4	Was condition related to employment? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, patient's date of birth			
	Does patient have Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No	Part A effective	Part B effective		
	<b>Subscriber's signature</b> 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 _____				

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