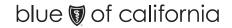
## An Independent Member of the Blue Shield Association CLM14850 (1/07)

## Subscriber's Statement of Claim



Send this claim to: Blue Shield of California, P.O. Box 272540, Chico, CA, 95927-2540.

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.

Important instructions

• Sign your name in the space provided

Duplicate claims will not only be rejected but may delay payment of the original claim.

Use a separate form for:	Exeptions:
A. Each member of the family	<ul> <li>Primary Medicare coverage</li> </ul>
B. Each different provider of service	A. Submit claim to Medicare first.
C. Each itemized bill	B. Complete boxes 1 and 4 only.
Print of type	C. Attach your explanation of Medicare benefits form and a cop
Fill in all items completely	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

Failure to comply with these instructions may result in your claim being delayed or returned to you.		must include the US currency exchange rate or value and the translation for all billed services.				
1						
Subscriber name (Last, First, MI)		Subscriber number		Group number		
Mail address	City	ity		ZIP Is address new?		
2						
Patient's name		Date of birth (mo/day,	⁄yr) Gender ☐ Malı ☐ Fem			
Describe briefly patient's illness or injury and, if injury, how it occured						
Patient was treated for Injury Illness Pregnancy Date of injury, onset of illness or p		pregnancy   Is patient retired?   If Yes   No			tive date	
3						
Does patient have other health coverage?  Yes No	es, policy ID number	Name of insuring company		E	ffective date	
Address of insuring company				Type o ☐ Gr	f plan oup	
Name of policy holder	Gender ☐ Male ☐ Female	Date of birth N (mo/day/yr)	lame of employer			
4	:	-	·			
Was condition related to employment? ☐ Yes ☐ No	Does patient have Medicare?  Yes No	If Yes, date of birth (mo/day/yr)	Part A effective date	e 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.

Date