



CLAIM CONTROL NUMBER • FOR BLUE CROSS USE ONLY

Blue Cross is an Independent Licensee of the Blue Cross Association  
On Behalf of BC Life and Health Insurance Company

PATIENT INFORMATION	MEMBER INFORMATION
NAME <input type="text"/>	I.D. NUMBER <input type="text"/>
LAST FIRST MIDDLE	GROUP NO. <input type="text"/> DAYTIME PHONE NO. <input type="text"/>
DATE OF BIRTH <input type="text"/> SEX <input type="text"/> RELATIONSHIP TO SUBSCRIBER <input type="text"/>	NAME <input type="text"/>
MO DAY YR M F SELF SPOUSE CHILD	LAST FIRST MIDDLE
OCCUPATION <input type="text"/>	STREET ADDRESS <input type="text"/>
EMPLOYER <input type="text"/>	CITY <input type="text"/> STATE <input type="text"/> ZIP <input type="text"/>
IS PATIENT COVERED BY MEDICARE? <input type="checkbox"/> YES <input type="checkbox"/> NO	NEW ADDRESS <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, HAVE EMPLOYEE SIGN THIS FORM.
IF "YES" MEDICARE I.D. NUMBER <input type="text"/>	MEMBER'S MARITAL STATUS IF OTHER COVERAGE EXISTS: <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> LEGALLY SEPARATED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED
EFFECTIVE DATES (HOSP) PART A <input type="text"/> (MED) PART B <input type="text"/>	COMPLETE IF YOU ARE MARRIED:
MO DAY YR MO DAY YR	NAME OF SPOUSE <input type="text"/> DATE OF BIRTH <input type="text"/> SOCIAL SECURITY NUMBER <input type="text"/>
DATE OF INJURY, ONSET OF ILLNESS OR PREGNANCY <input type="text"/>	IS YOUR SPOUSE EMPLOYED? <input type="checkbox"/> YES <input type="checkbox"/> NO
PATIENT WAS TREATED FOR: <input type="checkbox"/> INJURY <input type="checkbox"/> ILLNESS <input type="checkbox"/> PREGNANCY	IF YES, NAME AND LOCATION OF SPOUSE'S EMPLOYER:
MO DAY YR	EMPLOYER'S NAME AND ADDRESS <input type="text"/>
WAS CONDITION RELATED TO EMPLOYMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	NAME OF SPOUSE'S GROUP HEALTH PLAN <input type="text"/>
DESCRIBE BRIEFLY PATIENT'S ILLNESS OR INJURY IF INJURY, HOW IT OCCURED.	IF DIVORCED OR LEGALLY SEPARATED, AND CLAIM IS FOR A DEPENDENT CHILD, PLEASE FURNISH THE FOLLOWING:
	OTHER PARENT'S NAME <input type="text"/>
	LAST FIRST MIDDLE
	ADDRESS <input type="text"/>
	EMPLOYER'S NAME AND ADDRESS <input type="text"/>
OTHER INSURANCE INFORMATION	
DOES PATIENT HAVE OTHER HEALTH INSURANCE? <input type="checkbox"/> YES <input type="checkbox"/> NO	
POLICY HOLDER NAME <input type="text"/>	
INSURANCE COMPANY NAME AND ADDRESS <input type="text"/>	
EFFECTIVE DATE <input type="text"/> POLICY NUMBER <input type="text"/>	
MO DAY YR	

## REFERRING PHYSICIAN

If the bill is from an Audiologist or Occupational, Physical, Respiratory or Speech Therapist, what is the name of the physician who ordered the service?

Dr. \_\_\_\_\_

Please read both sides of this form carefully. Use a separate Patient Claim Form for EACH PATIENT. Please PRINT or TYPE.  
**YOUR COOPERATION IN COMPLETING ALL ITEMS ON THE CLAIM FORM AND ATTACHING ALL REQUIRED DOCUMENTATION WILL HELP EXPEDITE QUICK AND ACCURATE PROCESSING OF YOUR CLAIM.**

<input type="text"/> TOTAL NUMBER OF BILLS ATTACHED	I certify that the information on this claim form is true and correct to the best of my knowledge. I authorize the release of any medical information necessary to process this claim.
	PATIENT'S SIGNATURE (PARENT'S SIGNATURE IF PATIENT IS A MINOR.) _____ DATE _____

## ABOUT THIS FORM

Dear PERSCare / PERS Choice Member:

Usually, all providers of health care will bill us directly for services to you and your enrolled dependents.

This is the preferred procedure—you are not bothered with claim forms, and we often need more details than are ordinarily provided on bills to patients.

But sometimes a physician may not bill us. Or an ambulance company, for example, may send the bill directly to you. In either instance, we have no way of knowing about your claim.

This is why this form was developed. Use it to notify us of any covered health service for which we have not already been billed. You are urged to send us each bill immediately upon receipt.

Please read the instructions about how to use this form. It is for your convenience.

We are happy to serve you.

## HOW TO USE THIS FORM

- Please complete a separate claim form for each patient.
- Attach original medical bills. We suggest that you keep copies for your records.
- If you are enrolled in Medicare, attach a clear copy of the Explanation of Benefits you receive from Medicare.
- If Blue Cross is not your prime carrier, please include an Explanation of Benefits from your other carrier.

## WHEN TO USE THIS FORM

- Each time you submit bills, including those for ambulance services and appliances not usually billed directly to Blue Cross.
- Do not use this form for bills which are being sent directly to Blue Cross by the hospital, doctor, or laboratory.

## BILLS MUST BE ITEMIZED

Cancelled check, cash register receipts and non-itemized "balance due" statements cannot be processed. Each itemized bill must include:

1. Name and address of provider (doctor, hospital, laboratory, or ambulance service, etc.)
2. Name of patient
3. Date of service
4. Amount charged for each service
5. Diagnosis or reason for treatment

***Write your Group Number and your PERSCare or PERS Choice ID Number on the face of each bill.***

## THE FOLLOWING INFORMATION MUST ALSO BE INCLUDED ON BILLS FOR THESE ITEMS:

### REGISTERED AND LICENSED VOCATIONAL NURSES:

- Hours and dates of service
- Location of service (residence or name of hospital)
- Written documentation of physician's referral (must include the state license number, plan of treatment and estimated duration of treatments)

### PROSTHETIC DEVICES, APPLIANCES OR DURABLE MEDICAL EQUIPMENT:

- Doctor's orders or prescriptions
- Purchase price

### AMBULANCE

- Pick-up and delivery points
- Number of miles

## WHERE TO SEND COMPLETED CLAIM FORMS

Mail completed form plus itemized bills to:  
Blue Cross of California  
PO Box 4386  
Woodland Hills, CA 91365-4386

## CLAIM INFORMATION

Claims or benefit questions will be answered by calling 1-877-PERSPPO (1-877-737-7776).

For prescription drug reimbursement claim forms, please call Merck-Medco Member Services at 1-800-316-9178.