Blue Shield of California
Life & Health Insurance Company
An Independent Licensee of the Blue Shield Association

P.O. Box 9000, London, KY 40742
1-866-510-8778

SHORT TERM HEALTH INSURANCE CLAIM FORM FOR BLUE SHIELD OF CALIFORNIA LIFE & HEALTH INSURANCE COMPANY (BLUE SHIELD LIFE)

1. Please complete the entire enrollment form. This form cannot be processed if information is incomplete. PLEASE PRINT ALL SECTIONS IN BLACK INK.
2. Attach itemized bills or prescription receipts.
3. Sign the Authorization below.
4. Send the completed form directly to Blue Shield Life at the address shown above.

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

SECTION 1

NAME OF THE INSURED	TELEPHONE NO.	SOCIAL SECURITY NO.	POLICY NO.
MAIL ADDRESS	CITY	STATE	ZIP
NAME OF PATIENT		BIRTHDATE (mo./day/yr.)	RELATIONSHIP

Have you, your spouse or covered children been insured under another health plan during the twelve months prior to the effective date of this policy?

☐ Yes ☐ No If "Yes," complete the following: (if there was more than one insurance carrier, please attach a separate page with the following information about each plan)

POLICYHOLDER NAME	POLICY OR ID#	GROUP NUMBER	EFFECTIVE/TERMS DATES
NAME OF INSURANCE COMPANY	ADDRESS OF CLAIMS OFFICE		TELEPHONE NO. OF CLAIMS OFFICE
EMPLOYER OR GOVERNMENT SERVICE NAME	EMPLOYER OR GOVERNMENT SERVICE ADDRESS		TELEPHONE NO.

SECTION 2

DESCRIBE CONDITION RESPONSIBLE FOR EXPENSES (If injury, provide details of injury, including date.)

EXPENSES WERE THE RESULT OF: ☐ Injury ☐ Illness ☐ Pregnancy	Date treatment first occurred (mo./day/yr.)	Date symptoms were first noticed (mo./day/yr.)

PHYSICIAN'S NAME

PHYSICIAN'S COMPLETE ADDRESS	TELEPHONE NO. ( )

SECTION 3

Please sign this assignment of benefits if you wish payment to be made to any of the health care providers listed below:
I authorize payment of benefits to the provider(s) indicated below:

INSURED OR AUTHORIZED PERSON: ______________________ **DATE:**______________

LIST BELOW ALL PHYSICIANS AND OTHER HEALTH CARE PROVIDERS SEEN FOR THIS CONDITION:

NAME	ADDRESS	TELEPHONE NO.	DATES SEEN	ASSIGNMENT?
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

AUTHORIZATION TO OBTAIN INFORMATION

I authorize these persons having any records or knowledge of me or my health: physician, medical or health care provider, hospital, clinic, pharmacy or other medical or medically related facility, insurance company, employer or plan administrator, government agency, organization or entity administering a benefit program, educational, vocational or rehabilitation organization or program, to give this information: all medical information on me, including medical history, diagnosis, prognosis and treatment of any physical or mental condition, to Blue Shield Life. I understand that Blue Shield Life will use the information to determine my eligibility or entitlement for insurance benefits. I understand I have right of access and correction with respect to all personal information provided under this authorization. Blue Shield Life may release information about me to a reinsurer, a plan administrator, or any person performing business for legal services or Blue Shield Life in connection with my claim. I understand and agree that this authorization shall remain in force throughout the duration of my claim for benefits with Blue Shield Life. A photocopy of this authorization is as valid as the original.

Insured/Patient ______________________ **X** ______________________ ______________

Print Name Signature Date