Blue Shield of California
An Independent Member of the Blue Shield Association

BlueCard Worldwide®
International Claim Form

Send Completed form to: **Blue Shield of California, Foreign Claims**
P. O. Box 272550
Chico, CA 95927-2550

1. Patient Information – 1A. Alpha prefix **Identification number** *(Copy this from your Blue Shield ID Card)*

1B. Patient's name (First, middle initial, last)	**1C. Patient's date of birth** MM/DD/YYYY / /	**1D. Patient's sex** ❑ Male ❑ Female
1E. Name of subscriber (First, middle initial, last)	**1F. Subscriber's date of birth** MM/DD/YYYY / /	**1G. Patient's relationship to subscriber** ❑ Self ❑ Spouse ❑ Child

1H. Subscriber's current mailing address (Street, city, state, and country or ZIP code)

2. Other Health Insurance – Is the patient covered under other health insurance, including Medicare A or B? ❑ Yes ❑ No
If yes, complete 2A through 2K below.

2A. Name and address of insuring company

2B. Type of contract ❑ Family ❑ Individual	**2C. Effective date** MM/DD/YYYY / /	**2D. Termination date** MM/DD/YYYY / /	**2E. Policy or identification number of other coverage**
2F. Type of coverage Medical: ❑ Yes ❑ No	**2G. Name of contract holder**		**2H. Date of birth** MM/DD/YYYY / /

2I. Employer of contract holder

2J. Employment status ❑ Active employee ❑ Retired employee

2K. If patient is covered under Medicare, complete the following: Medicare Part A: ❑ Yes ❑ No Effective date ______ Medicare Part B: ❑ Yes ❑ No Effective date ______

3. Diagnosis – 3A. Describe illness, injury, or symptoms requiring treatment

3B. Was patient's treatment due to a work-related accident or condition? ❑ Yes ❑ No

3C. Complete for care related to accidental injuries

Date of accident ______ Location: ❑ At home ❑ Auto ❑ Other ______
Time of accident ______
If the accident was caused by someone else, attach a statement describing the accident.

4. Charges – Please list below those charges that you are claiming for benefits. Use a separate line for each type of service or provider and attach itemized bill for all services claimed.

4A. Type of provider	4B. Name of provider making charge	4C. Description of service	4D. Dates of service or purchase	4E. Charges

5. Signature – I certify the above is complete and correct and that I am claiming benefits only for charges incurred by the patient named above. Authorization is hereby given to any provider of service, which participated in any way in the patient's care, to release to Blue Shield of California any medical information which they deem necessary to adjudicate this claim.

Signature of subscriber or patient ______ Date ______

6. Authorization for Assignment of Benefits

I, the undersigned, authorize and request Blue Shield of California to make payment for benefits due herein to:

Signature of subscriber or spouse ______ Date ______