



# United States Department of the Interior

## NATIONAL PARK SERVICE

Yosemite Medical Clinic

P. O. Box 550

Yosemite, California 95389

### Subscriber's Statement of Claim

This form is to be used ONLY when Yosemite Medical Clinic does not submit your claim directly to Blue Cross Blue Shield.

Check with the Clinic to be sure no claim has been submitted.

Duplicate claims will be rejected or delay payment of the original claim.

**Mail complete packet to: Blue Shield of California, PO Box 1505, Red Bluff, CA 96080-1505**

### Important instructions

- Use a separate form for
  - Each member of the family
  - Each visit to the clinic
- Print or type
- Fill in all items completely
- Sign your name in the space provided
- Include itemized receipt indicating payment
- Failure to comply with instructions may result in your claim being delayed or returned to you
- If you have Primary Medicare Coverage
  - Submit claim to Medicare first
  - Complete boxes 1 and 4 only
  - Attach your Explanation of Medicare Benefits form And a copy of itemized services to this claim and Send all to Blue Cross Blue Shield

Subscriber name (Last, First, MI)	Member ID/Subscriber number	Group number (if applicable)
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Mail address (Street, City, State, ZIP)	Is address new? <input type="checkbox"/> Yes <input type="checkbox"/> No
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2 Name of patient (Last, First, MI)	Date of birth (month, day, year)
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Relationship to subscriber <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Domestic partner	Patient's gender <input type="checkbox"/> Male <input type="checkbox"/> Female
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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	Is patient retired? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, effective date
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3 Does patient have other health coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, policy ID No.	Name of insuring company	Effective date
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Address of insuring company	Type of plan <input type="checkbox"/> Group <input type="checkbox"/> Individual
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Name of Policy Holder	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of birth	Name of Employer
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4 Was condition related to employment? <input type="checkbox"/> Yes <input type="checkbox"/> No	Does patient have Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Part A effective date:	If Yes, Part B effective date:
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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 a state prison.

I certify that the foregoing information is accurate and complete, and authorize the release of any medical information necessary to process this claim.

Subscriber signature

X \_\_\_\_\_ Date: \_\_\_\_\_