COMMUNITY HEALTH PLAN OF THE SISKIYOUS

For your quality of life

MEMBER CLAIM

Fill out a separate form for each member submitting bills for covered services.
MAIL COMPLETED FORM WITH BILLS AND PROOFS OF PAYMENT TO: BRMS, PO BOX 2650, RANCHO CORDOVA, CA 95741-2650.

PLEASE TYPE OR PRINT

SUBSCRIBER INFORMATION

SOCIAL SECURITY #	NAME: LAST FIRST MI	BIRTH DATE (Mo/Day/Yr)
SUBSCRIBER SSN MUST BE INDICATED TO ASSURE PROMPT PROCESSING OF THIS REQUEST		

ADDRESS	CITY	STATE	ZIP	TELEPHONE #
				( )

PATIENT INFORMATION

NAME LAST FIRST MI	BIRTH DATE (Mo/Day/Yr)	RELATIONSHIP TO SUBSCRIBER	BRMS GROUP #
		☐ SELF ☐ SPOUSE ☐ OTHER ☐ DAUGHTER ☐ SON	

BRMS MEDICAL GROUP NAME	WAS THE PATIENT OUT OF AREA FROM HIS / HER MEDICAL GROUP?	IF YES INDICATE REASON
	☐ YES ☐ NO	☐ BUSINESS ☐ VACATION ☐ OTHER_____ ☐ SCHOOL ☐ CHANGE OF ADDRESS

MEDICAL EMERGENCY?	IS THIS ILLNESS OR INJURY WORK RELATED?	IF YES, INDICATE DATE OF INJURY AND EMPLOYER NAME
☐ YES IF YES. GIVE DATE OF EMERGENCY ☐ NO	☐ YES ☐ NO	(DATE) (NAME)

OTHER HEALTH INSURANCE

IS PATIENT PRESENTLY COVERED BY OTHER MEDICAL INSURANCE, INCLUDING MEDICARE?	IF YES. PLEASE COMPLETE THIS SECTION	OTHER INSURANCE COMPANY NAME
☐ YES ☐ NO		

ADDRESS	CITY	STATE	ZIP	POLICY#	EFFECTIVE DATE

NAME OF INSURED POLICYHOLDER	BIRTH DATE (Mo/Day/Yr)	EMPLOYER NAME

EMPLOYER ADDRESS	FOR MEDICARE, INDICATE PARTS MEMBER IS ENROLLED IN	PART A	PART B
		☐ YES ☐ NO	☐ YES ☐ NO

Use this portion to report any accidental injury or emergency illness not treated by your BRMS medical group. Attach a bill or photocopy. Please be sure that duplicate bills are not submitted. If you are covered by another insurance carrier, please attach the Explanation of Benefits, which you can obtain from the other insurance carrier.

DATE OF SERVICE Mo / Day / Yr	PROVIDER OF SERVICE (Doctor, Lab, Ambul. Comp., RN, etc.)	DESCRIPTION OF SERVICES RENDERED	ILLNESS OR DIAGNOSIS	TOTAL CHARGE	AMOUNT PAID BY YOU

NAME OF PERSON TO RECEIVE PAYMENT OR REIMBURSEMENT	RELATIONSHIP TO SUBSCRIBER
	☐ SELF ☐ SPOUSE ☐ OTHER_____

NAME OF PERSON PREPARING FORM (PLEASE PRINT)	DATE	SUBSCRIBER SIGNATURE
		X