



You must attach the **signed** "Super Bill" or the **signed** "Invoice" from the Provider of Services for this claim to be processed. You must use one form per provider of services. This claim will not be processed and may result in non-payment without the attached bill or invoice.

Subscriber Information	
Subscriber Name (Last, First, MI)	Subscriber ID

Patient's Information		
Patient's Name (Last, First, MI)	Patient's Member ID	
Patient's Date of Birth	Patient's Sex	Relationship to Subscriber
	Male <input type="checkbox"/> Female <input type="checkbox"/>	Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependant <input type="checkbox"/>
Other Insurance Name	Other Insurance ID Number	Is Patient's condition related to:
		Auto <input type="checkbox"/> Other <input type="checkbox"/> Employment <input type="checkbox"/>
Patient's Address		
Street		
City	State	Zip

<b>I certify that the information above is correct. I also understand that it is a crime to knowingly make any false statement to obtain compensation.</b>	
Signature	Date

<b>Insured's or Authorized Person's Signature</b> I authorize payment of medical benefits to the physician or supplier of services listed below:	
Provider Name	Tax ID
Signature	Date

Please mail your completed claim form to:

ASHIC  
PO BOX 509077  
SAN DIEGO, CA 92150-9077

Any person who knowingly and with intent to injure, defraud or deceive any insurance company files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.