blue of california

Prior Carrier Accumulation (PCA)
Member Request Form

1. Your Full Name: _____ **Today's Date:** _____

2. Your Blue Shield Identification#: _____ **3. Your plan effective date:** _____

To credit your Prior Carrier Accumulation we need to know the amount to be credited for each member of your plan. If your total deductible was met by only one member, then we only need information for that member. We cannot credit a "family deductible." We need to know the amount of the "family deductible" each family member met.

4. Acceptable proof of PCA met:

- The most recent Explanation of Benefits (EOB) for each member (please do not include more than one page per member) **or,**
- A letter from your previous carrier indicating the amount each member has accumulated **or,**
- A pharmacy printout showing your total deductible amount met (if applicable).

5. Please enter the accumulation amount met by each member:

Name					
Deductible	$	$	$	$	$
Other:_____	$	$	$	$	$
Internal use only					

6. Is this is a request for an additional amount to be credited? (If you previously submitted an accumulation request and now have additional credits to apply) If yes, please complete below, including the name for each member you are requesting additional credit, the original amount you previously submitted, and the additional amount you are adding to the original amount.

Name				
Original Amount	$	$	$	$
Additional Amount	$	$	$	$

Internal Use Only

Benefit	B/N	Plan Type	EFFT DT	Count	Adj Med	Adj Pre	Pre SS