International Claim Form

Send completed form and documentation to: Service Center

Please see the instructions on the reverse side of this form before completing.



Blue Cross and Blue Shield Companies are independent licensees of the Blue Cross and Blue Shield Association.

or online at <u>www.bcbsglobalcore.com</u> P.O. Box 2048 Southeastern, PA 19399						Cross and Blue Shield Association.		
1. Patient Information —	1A. Alpha prefix Identificatio	on numbe	er Copy th	nis from y	your Blue Cross	Blue Shield identific	ation card.	
1B. Patient's name (First, middle initial, last)			1C. Patient's date of birth			1D. Patient's sex Male Female		
1E. Name of subscriber (First, middle initial, last)			1F. Subscriber's date of birth			1G. Patient's relationship to subscriber		
		MM/DD/YYYY			Self Spouse Child			
1H. Subscriber's current mai	ZIP code)			1I. Patient's e-mail address				
2. Other Health Insurance	- Is the patient covered und If yes, complete 2A through 2K I		r health insura	nce, in	cluding Medi	care A or B?	Yes No	
2A. Name and address of ot	her insuring company							
B. Type of policy 2C. Effective date Family Individual MM/DD/YYYY						licy or identification number er coverage		
2F. Type of coverage Hospital: Yes No			2G. Name of subscriber			2H. Date of birth		
Medical: Yes No Mental illness: Yes No						MM/DD/YYYY		
2I. Employer of subscriber				2J. Employment status				
					ve employee	Retired employee		
2K. If patient is covered unde	er Medicare, complete the folio	owing:	Medicare Part Effective date			Medicare Part B: Effective date	Yes No	
3. Diagnosis — 3A. Describe	e illness, injury, or symptoms re	equiring t	reatment and	onset c	late of symp	toms or injury.		
3B. Was patient's treatment d	ue to a work-related accident of	or condit	tion? Yes	No				
3C. Complete for care related				Auto	Other			
4. Charges — Use a separa	ate line to list each type of se	rvice or p	provider and a	ttach it	emized bills	for all services.		
4A. Name and address of 4B. Type of provider provider making charge			4C. Description of service 4D			Dates of service 4E. Charges or purchase		
Option A. Make payment Select your payment preference: If you want to receive an electronic f		b een paic Funds Trans	s fer – US Dollar			i sfer – Currency on it		
Bank's Physical Address:								
Account # /IBAN:			Routin	g # / ABA	/ BIC / SWIFT:			
	provider (hospital, doctor), if ap quest payment for benefits due herein Blue Shield company:		-		-		-	
Name of provider Signature of subscriber of			r spouse			Date		
is hereby given to any provider of se business associates in any country a	pove is complete and correct and that l rvice, that participated in any way in th ny medical or other personal information may differ among count	he patient's ition that the	care, to release to ey deem necessar	the subs	criber's Blue Cro ide service or ad	oss and Blue Shield c ljudicate this claim, r	ompany and its ecognizing that	

its business associates in any country to collect, use or release any medical or other personal information that they deem necessary to provide service, adjudicate a

claim or as otherwise described in such Blue Cross and Blue Shield company's Notice of Privacy Practices.

or

P.O. Box 2048

claims@bcbsglobalcore.com

Signature of subscriber or patient _

General Information

- The Blue Cross Blue Shield Global Core International Claim Form is to be used to submit institutional and professional claims for benefits for covered services received outside the United States, Puerto Rico and the U.S. Virgin Islands.
- For other claim types (e.g., dental, prescription drugs), contact your Blue Cross and Blue Shield Company for filing instructions.
- Please complete all fields. If the information requested does not apply to the patient, indicate N/A (Not Applicable).
- Please attach receipts and medical records (test results, x-rays, etc.), if available.
- · Please keep photocopies of all documentation for your personal records.

Itemized Bill Information

Each provider's original itemized bill must be attached and must contain:

- The letterhead indicating the name and address of the person or organization providing the service
- The full name of the patient receiving the service
- The date of each service
- A description of each service
- The charge for each service in local currency

SPECIAL CARE SHOULD BETAKEN WHEN COMPLETING THE FOLLOWING FIELDS:

1. Patient Information

1E. Name of subscriber – For check payments, provide your full name (initials are not acceptable).
1H. Subscriber's current mailing address – If check payment is requested, this address will be used. Please provide your physical address (payments cannot be sent to a P.O. Box).

2. Other Health Insurance

If the patient holds other insurance coverage, please complete items A through K as completely as possible. It is especially important to indicate the name and address of the other insurance company and the policy or identification number of that coverage, as well as the name and birth date of the person who holds that policy.

In addition, if the patient is someone other than the subscriber and has received benefits from any other health insurance plan held by reason of law or employment, the Explanation of Benefits Form furnished by the other carrier pertaining to these charges must be included with the claim. A clear photocopy of the other carrier's Explanation of Benefits Form is acceptable in place of the original document.

4. Charges

Please list the attached bills. Although itemized bills from the provider showing a separate charge for each service must be submitted, your listing will enable us to process the claim more quickly. If additional space is needed, please use a separate sheet of paper to list the following information:

- **4A. Name and Address of provider** as indicated on the bill. Multiple bills from the same provider may be included on the same line, as long as they are for the same type of service.
- 4B. Type of provider for example: hospital, nurse, physician, clinic, physical therapist, etc.
- 4C. Description of service for example: hospital admission, office visit, x-ray, laboratory test, surgery, etc.
- 4D. Date of service or purchase inclusive dates may be indicated for bills containing multiple dates of service.
- 4E. Charge —as indicated on the bill. If the bill has already been paid, please indicate the date it was paid.

5. Payee

Option A. Make payment to subscriber, designation of currency and payment method — Please note that not all forms of currency may be available for payment. In the event that you select payment in a currency that is not available, you will be paid in U.S. dollars. Banks may charge a fee to receive a wire. You may want to research fees charged by your bank prior to requesting a wire since you will be responsible for any such fees.

For an electronic funds transfer, provide the bank's physical address where the account was opened (not a P.O. Box). Please provide a copy of a voided check or deposit slip so that the bank information can be validated.

Option B. Authorization for payment to provider — complete option B if you prefer that benefits be paid directly to the provider of service. Direct payment to the provider is at the discretion of your Blue Cross and Blue Shield Company, except where required by law.

6. Signature

The International Claim Form must be signed and dated by the subscriber, spouse, or the patient.

Disclosure Statement

Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.