International Claim Form

Send completed form and documentation to: Service Center

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



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or online at <u>www.bcbsgloba</u>	alcore.com P.O. Box 2048 Southeastern, F	PA 19399				Cross and Blue Shi	eld Association.	
1. Patient Information	— 1A. Alpha prefix Identificatio	on numbe	r Copy th	is from y	/our Blue Cro	oss Blue Shield identifica	tion card.	
1B. Patient's name (First, middle initial, last)			1C. Patient's date of birth			1D. Patient's sex		
1E. Name of subscriber (First, middle initial, last)			1F. Subscriber's date of birth			1G. Patient's relationship to subscriber		
						Self Spouse Child		
1H. Subscriber's current r	mailing address (Street, city, state, and	d country or Z	(IP code)			1l. Patient's e	-mail address	
2. Other Health Insura	nce — Is the patient covered un If yes, complete 2A through 2K		health insura	nce, ind	cluding Me	edicare A or B?	∕es □ No	
2A. Name and address of	other insuring company							
2B. Type of policy Family Individual					licy or identification number er coverage			
2F. Type of coverage	Hospital: Yes No Mental illness: Yes No	2G. Na	Name of subscriber		I	2H. Date of birth		
21. Employer of subscribe					nployment ve employee			
2K. If patient is covered u	•	-			Medicare Part B: □ Yes □No Effective date			
3. Diagnosis — 3A. Desc	ribe illness, injury, or symptoms r	requiring t	eatment and	onset d	late of syn	nptoms or injury.		
3B. Was patient's treatmer	nt due to a work-related accident	or conditi	ion? □ Yes □] No				
	ated to accidental injuries							
Date of accident		Location:	□ At home	🗆 Auto	Other			
Time of accident		If the accide	nt was caused by	someone	e else, attach	a statement describing t	he accident.	
 Charges — Use a sep 4A. Name and address of provider making charge 	parate line to list each type of se 4B. Type of provider	-	rovider and a cription of servic			Is for all services. D. Dates of service or purchase	4E. Charges	
Option A. Make paym Select your payment preference If you want to receive an electro	of the following payment optio ent to subscriber; provider has e: Check – US Dollar Electronic nic funds transfer provide the following: s on bank account:	been paid Funds Trans	fer – US Dollar			ransfer – Currency on ite		
Bank's Physical Address:								
Account # /IBAN:	Routing # / ABA / BIC / SWIFT:							
Option B. Make paymen	t to provider (hospital, doctor), if a	appropriate	. Please comp	ete and	l sign to au	thorize direct payme	ent to provider.	
l, the undersigned, authorize and by the subscriber's Blue Cross a	d request payment for benefits due herein nd Blue Shield company:	n to be made	to the following	provider	of services, if	such direct payment is o	deemed appropriat	
Name of provider	Signature of	Signature of subscriber or				Date	Date	
is hereby given to any provider of business associates in any count applicable law concerning perso	ne above is complete and correct and that of service, that participated in any way in t try any medical or other personal informa- onal information may differ among coun ountry to collect, use or release any mec	the patient's ation that the ntries. Author	care, to release to y deem necessary ization is also giv	the subs y to provi en to the	criber's Blue ide service or subscriber's	Cross and Blue Shield co adjudicate this claim, re Blue Cross and Blue Sh	mpany and its cognizing that iield company and	

or

P.O. Box 2048

claims@bcbsglobalcore.com

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

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 BE TAKEN 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.