International Claim Form



Date _

Send completed form and documentation to: Service Center or online at www.bcbsglobalcore.com

Signature of subscriber or patient _

P.O. Box 2048

or claims@bcbsglobalcore.com

Southeastern, PA 19399

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

1. Patient Information	— 1A. Alpha prefix Identification	on number Copy t	his from yo	ur Blue Cross	Blue Shield identific	cation card.	
1B. Patient's name (First, mi	_	1C. Patient's date of birth			1D. Patient's sex		
	MM/DD/YYYY				Male Female		
1E. Name of subscriber (Fi	1F. Subscriber's date of birth			1G. Patient's relationship to subscriber			
411 Cultarailtari/a accumant in		MM/DD/YYYY			·	ouse Child	
in. Subscriber's current n	nailing address (Street, city, state, and	d country or ZIP code)			II. Patient's	e-mail address	
2. Other Health Insuran	If yes, complete 2A through 2K		ance, incl	uding Medi	care A or B?	Yes No	
2A. Name and address of	other insuring company						
2B. Type of policy	e of policy 2C. Effective date 2D. Termination date 2E. Policy				or identification number		
Family Individual	MM/DD/YYYY	MM/DD/YYYY			coverage		
2F. Type of coverage	Hospital: Yes No	2G. Name of subscr	iber		2H. Date of I	oirth	
••	Mental illness: Yes No				MM/DD/YYYY		
2I. Employer of subscribe		-1		ployment st	tatus Retired employee		
2K If nationt is covered ur	nder Medicare, complete the follo	lowing: Medicare Par			Medicare Part B:	Yes No	
en. Il patient is covered di	idei Medicale, complete the los	Effective date			Effective date		
3. Diagnosis — 3A. Desc	ribe illness, injury, or symptoms r	equiring treatment and	onset da	te of symp	toms or injury.		
Time of accident	arate line to list each type of se		attach ite	else, attach a st mized bills t 4D. [the accident. 4E. Charges	
Option A. Make payment Select your payment preference: If you want to receive an electror	of the following payment option ent to subscriber; provider has Check – US Dollar Electronic funds transfer provide the following:	been paid. Funds Transfer – US Dollar			sfer – Currency on i		
	_Routing # / ABA / BIC / SWIFT:						
Option B. Make payment	to provider (hospital, doctor), if a	appropriate. Please comp	lete and	sign to autho	orize direct paym	ent to provide	
	request payment for benefits due herei			_		-	
Name of provider	Signature of	subscriber or spouse	er or spouse			Date	
is hereby given to any provider o business associates in any count applicable law concerning perso its business associates in any co	e above is complete and correct and that f service, that participated in any way in to y any medical or other personal information and information may differ among coun untry to collect, use or release any med in such Blue Cross and Blue Shield con	the patient's care, to release to ation that they deem necessal tries. Authorization is also gi lical or other personal inform	o the subsc ry to provid ven to the s nation that t	riber's Blue Cro e service or ad subscriber's Blo	ss and Blue Shield o judicate this claim, r ue Cross and Blue S	company and its recognizing that Shield company ar	

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.