International Claim Form



Date _

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

Signature of subscriber or patient _

or claims@bcbsglobalcore.com

P.O. Box 2048 Southeastern, PA 19399

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1. Patient Information -	— 1A. Alpha prefix Identificatio	on number	his from your Blu	e Cross Blue Shield identifi	cation card.	
1B. Patient's name (First, mic	1C. Patient's date of birth			1D. Patient's sex Male Female		
1E. Name of subscriber (Fin	1F. Subscriber's date of birth			1G. Patient's relationship to subscriber		
411.0.1.111.7		MM/DD/YYYY			ouse Child	
1H. Subscriber's current m	nailing address (Street, city, state, and	d country or ZIP code)		11. Patient's	e-mail addres	
2. Other Health Insuran	ce — Is the patient covered un If yes, complete 2A through 2K		nce, including	g Medicare A or B?	Yes No	
2A. Name and address of	other insuring company					
2B. Type of policy Family Individual	2C. Effective date	=		Policy or identification there	or identification number	
	Hospital: Yes No	2G. Name of subscri		2H. Date of	birth	
••	Mental illness: Yes No			MM/DD/YYYY		
2I. Employer of subscriber		2J. Employi	pyment status nployee Retired employee			
2K. If patient is covered un	der Medicare, complete the foll	owing: Medicare Part		No Medicare Part B:	Yes No	
•	•	Effective date)	Effective date		
Time of accident	•		someone else, a		the accident. 4E. Charges	
Option A. Make payme Select your payment preference: If you want to receive an electron Subscriber name as it appears	ic funds transfer provide the following: on bank account:	been paid. Funds Transfer – US Dollar	Bank name:	nds Transfer – Currency on i		
•		Routing # / ABA / BIC / SWIFT:				
• • •	to provider (hospital, doctor), if a request payment for benefits due herein d Blue Shield company:		_	• •	-	
Name of provider	Signature of	subscriber or spouse	or spouse		Date	
is hereby given to any provider of business associates in any countr applicable law concerning persor its business associates in any co	e above is complete and correct and that service, that participated in any way in t y any medical or other personal informa nal information may differ among count untry to collect, use or release any med in such Blue Cross and Blue Shield com	the patient's care, to release to ation that they deem necessar tries. Authorization is also giv lical or other personal inform	the subscriber's y to provide serv en to the subscr ation that they d	Blue Cross and Blue Shield of ice or adjudicate this claim, iber's Blue Cross and Blue S	company and its recognizing that Shield company a	

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.