International Claim Form

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



Global。

Send completed form and documentation to: Service Center or online at <u>www.bcbsglobalcore.com</u> P.O. Box 2048 Southeastern I

1. Patient Information — 1A. Member ID

Service Center or <u>claims@bcbsglobalcore.com</u> P.O. Box 2048 Southeastern, PA 19399

Include all letters and numbers as shown on your Blue Cross Blue Shield identification card

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

1B. Patient's name (First, middle initial, last) 1C. Patient's date of birth MADDYYYY 1D. Patient's sex MADDYYYY 1E. Name of subscriber (first, middle initial, last) 1F. Subscriber's date of birth MADDYYYY 1G. Patient's relationship to subscriber 1H. Subscriber's current mailing address (Street, city, state, and country or 2P code) 11. Patient's erall address 2. Other Health Insurance - Is the patient covered under other health insurance, including Medicare A or B? Yes No // Yes, complete 2A through 2K below. 2A. Name and address of other insuring company 2B. Type of policy 2C. Effective date MADDYYYY 2F. Type of coverage Heaptist: Yes No 2G. Name of subscriber 2H. Date of birth MADDYYYY 2 Employer of subscriber 2J. Employment status 2A. Type of policy 2C. Effective date model (Street, complete the following: Medicare Part A: Yes No 2 Employer of subscriber 2J. Employment status 2A. Complete for care related accident or condition? Yes No 3C. Complete for care related accident all injuries 2. Mate and address of the collectual injuries 2. Care of accident Let accident all injuries 2. Complete for care related accident or condition? Yes No 3C. Complete for care related accident or condition? Wes No 3C. Complete for care related									
1E. Name of subscriber (First, middle initial, last) 1F. Subscriber's date of birth MADDYYYY 1G. Patient's relationship to subscriber 1H. Subscriber's current mailing address (Street, city, state, and country or 2P code) 1I. Patient's e-mail address 2. Other Health Insurance – Is the patient covered under other health insurance, including Medicare A or B? [Yes] No If yes, complete 2A through 2K below. 1I. Patient's e-mail address 2. Other Health Insurance or other insuring company 2E. Effective date MMODOYYY 2D. Termination date MMODOYYY 2E. Policy or identification number of other coverage 2.F. Type of policy Patient's low Medicat: Uves INO 2C. Effective date MMODOYYY 2I. Employment status AMODOYYY 2H. Date of birth MMODOYYY 2.E. Type of coverage Patient is covered under Medicare, complete the following: Medicare Part A: [Yes] No Medicare Part B:] Ves] No 2.K. If patient is covered under Medicare, complete the following: Medicare Part A: [Yes] No No 3. Diagnosis – 3A. Describe illness, injury, or symptoms requiring treatment and onset date of symptoms or injury. 3B. Vas patient's treatment due to a work-related accident or condition?] Ves] No 3.C. Complete for care related to accidental injuries Location:] At home] Auto] Other	1B. Patient's name (First, middle initial, last)								
MADDOVYYY I. Solit Spoulsa C. Nucl 11. Subsoriber's current mailing address (Street, city, state, and country or 2P code) 11. Patient's e-mail address 2. Other Health Insurance — Is the patient covered under other health insurance, including Medicare A or B? Yes No 2. Other Health Insurance — Is the patient covered under other health insurance, including Medicare A or B? Yes No 2. Name and address of other insuring company 26. Effective date 2D. Termination date ZE. Policy or identification number of other coverage 2. Fupe of coverage Hoapital: Yes No 23. Baye of subscriber 24. Date of birth Medicare Park S: Yes No 2. Employer of subscriber 2.1 Employment status Cattive employee Retired employee Retired employee 2.K. If patient is covered under Medicare, complete the following: Medicare Park A: Yes No Effective date Effective date Effective date Effective date Effective date MaDovyyy 3. Diagnosis — 3A. Describe illness, injury, or symptoms requiring treatment and onset date of symptoms or injury. 38. Was patient's treatment due to a work-related accident or condition? Yes No 3. Complete for care related to accidental injuries Location: A thom = Auto O	1E. Name of subscriber (First, middle initial, last)					1G. Patient's relationship to subscriber			
2. Other Health Insurance — Is the patient covered under other health insurance, including Medicare A or B? □ Yes □ No If yes, complete 2A through 2K below. 2A. Name and address of other insuring company 2B. Type of policy 2C. Effective date 2D. Termination date of other coverage 2F. Type of coverage Hospital: □ Yes □ No 2G. Name of subscriber 2H. Date of birth MMDDOVYYY 2I. Employer of subscriber 2H. Date of birth MMDDOVYY 2I. Employer of subscriber 2H. Date of birth MMDDOVYY 2I. Employer of subscriber 2H. Date of birth MMDDOVYY 2I. Employer of subscriber 2H. Date of birth MMDDOVYY 2I. Employer of subscriber 2H. Date of birth MMDDOVYY 2I. Employer of subscriber 2H. Date of birth MMDDOVYY 2I. Employer of subscriber 2H. Date of birth MMDDOVYY 2I. Employer of subscriber 2H. Date of birth MMDDOVYY 2I. Employer of subscriber 2H. Date of birth MMDDOVYY 2I. Employer of subscriber 2H. Date of birth MMDDOVYY 2I. Employer of subscriber 2H. Date of birth MMDDOVYY 2I. Employer of subscriber 2H. Date of birth MMDDOVYY 2I. Employer of subscriber 2H. Date of birth MMDDOVYY 2I. Employer of subscriber 2H. Date of birth MMDDOVYY 2I. Employer of subscriber 2H. Date of birth MMDDOVYY 2I. Employer of subscriber 2H. Date of birth MMDDOVYY 2I. Employer of subscriber 2H. Date of birth MMDDOVYY 2I. Employer of subscriber 2H. Date of birth MMDDOVYY 2I. Employer of subscriber 2H. Date of birth MMDDOVYY 2I. Employer of subscriber 2H. Date of birth Complete for care related to accidental injuries Date of faccident				MM/DD/YYYY					
If yes, complete 2A through 2K below. 2A. Name and address of other insuring company 2B. Type of policy 2C. Effective date MMDDVVVY MMDDVVVY 2F. Type of coverage Hospital: Uvs © No 2F. Type of oblicy 2C. Effective date 2F. Type of coverage Hospital: Uvs © No 2G. Name of subscriber 2H. Date of birth Medicat: Eves No Mental illness: Uvs © No 2I. Employer of subscriber 2J. Employer end tatus MADDVVVY Active employee 2K. If patient is covered under Medicare, complete the following: Medicare Part A: Vss © No 3C. Complete for care related to a work-related accident or condition? Vss © No SC. Complete for care related to accidental injuries Date of accident	1H. Subscriber's current mai	ling address (Street, city, state, and	country or	ZIP code)			1. Patient's	e-mail address	
If yes, complete 2A through 2K below. 2A. Name and address of other insuring company 2B. Type of policy 2C. Effective date MMDDVVVY MMDDVVVY 2F. Type of coverage Hospital: Uvs © No 2F. Type of oblicy 2C. Effective date 2F. Type of coverage Hospital: Uvs © No 2G. Name of subscriber 2H. Date of birth Medicat: Eves No Mental illness: Uvs © No 2I. Employer of subscriber 2J. Employer end tatus MADDVVVY Active employee 2K. If patient is covered under Medicare, complete the following: Medicare Part A: Vss © No 3C. Complete for care related to a work-related accident or condition? Vss © No SC. Complete for care related to accidental injuries Date of accident									
2B. Type of policy 2C. Effective date 2D. Termination date 2E. Policy or identification number of other coverage 2F. Type of coverage MMDDYYYY MMDDYYYY 2G. Name of subscriber 2H. Date of birth Medicat: Image: State of Subscriber 2J. Employment status Active employee Retired employee 2I. Employer of subscriber 2J. Employment status Active employee Retired employee 2K. If patient is covered under Medicare, complete the following: Medicare Part A: Yes No 3. Diagnosis - 3A. Describe illness, injury, or symptoms requiring treatment and onset date of symptoms or injury. 3B. Was patient's treatment due to a work-related accident or condition? Yes No 3. Diagnosis - 3A. Describe illness, injury, or symptoms requiring treatment and onset date of symptoms or injury. 3B. Was patient's treatment due to a work-related accident or condition? Yes No 3. Complete for care related to accidental injuries Location: A thome Auto: Other Time of accident	2. Other Health Insurance	-		r health insura	nce, in	cluding Medic	are A or B? 🛛	Yes 🗆 No	
Image: Parmity individual MMDDYYYY of other coverage 2F. Type of coverage Hospital: Image: Yes in No 2G. Name of subscriber 2H. Date of birth 2I. Employer of subscriber 2J. Employment status Image: Active employee 2J. Employment status 2K. If patient is covered under Medicare, complete the following: Medicare Part A: Yes No Nedicare Part A: Yes No 2K. If patient is covered under Medicare, complete the following: Medicare Part A: Yes No Nedicare Part A: Yes No 3. Diagnosis - 3A. Describe illness, injury, or symptoms requiring treatment and onset date of symptoms or injury. 3B. Was patient's treatment due to a work-related accident or condition? Yes No 3C. Complete for care related to accidental injuries Location: At home Auto Other Employee Time of accident If the accident was caused by someone else, attach a statement describing the accident. 4C. Charges — Use a separate line to list each type of service or provider and attach itemized bills for all services. 4A. Alare and address of provider 4B. Type of provider 4C. Description of service 4D. Dates of service or purchase 5. Payee — Select one of the following payment options: Cyticat Bane name: Bank's Physical Address: Account #/RBAN: Bank name: Bank's Physical Address: Routing #/ABA / BIC / SWIFT:	2A. Name and address of ot	her insuring company							
Image: Parmity individual MMDDYYYY of other coverage 2F. Type of coverage Hospital: Image: Yes in No 2G. Name of subscriber 2H. Date of birth 2I. Employer of subscriber 2J. Employment status Image: Active employee 2J. Employment status 2K. If patient is covered under Medicare, complete the following: Medicare Part A: Yes No Nedicare Part A: Yes No 2K. If patient is covered under Medicare, complete the following: Medicare Part A: Yes No Nedicare Part A: Yes No 3. Diagnosis - 3A. Describe illness, injury, or symptoms requiring treatment and onset date of symptoms or injury. 3B. Was patient's treatment due to a work-related accident or condition? Yes No 3C. Complete for care related to accidental injuries Location: At home Auto Other Employee Time of accident If the accident was caused by someone else, attach a statement describing the accident. 4C. Charges — Use a separate line to list each type of service or provider and attach itemized bills for all services. 4A. Alare and address of provider 4B. Type of provider 4C. Description of service 4D. Dates of service or purchase 5. Payee — Select one of the following payment options: Cyticat Bane name: Bank's Physical Address: Account #/RBAN: Bank name: Bank's Physical Address: Routing #/ABA / BIC / SWIFT:		20 Effective data	2D T-						
2F. Type of coverage Hospital: Ves No 2G. Name of subscriber 2H. Date of birth Medical: Ves No Mental illness: Ves No 2I. Employer of subscriber 2J. Employment status Cative employee Retired employee 2K. If patient is covered under Medicare, complete the following: Medicare Part A: Ves No Medicare Part B: Ves No 3. Diagnosis -3A. Describe illness, injury, or symptoms requiring treatment and onset date of symptoms or injury. 38. Was patient's treatment due to a work-related accident or condition? Yes No 3B. Was patient's treatment due to a work-related accident or condition? Yes No Sc. Complete for care related to accidental injuries Date of accident			_	-		-			
Medical: No Mental illness: Ves No 21. Employer of subscriber 2.1. Employer of subscriber 2.1. Employee of subscriber 2K. If patient is covered under Medicare, complete the following: Medicare Part A: No Medicare Part B: Yes No 3. Diagnosis -3A. Describe illness, injury, or symptoms requiring treatment and onset date of symptoms or injury. 38. Was patient's treatment due to a work-related accident or condition? Yes No 32. Complete for care related to accidental injuries Location: A thore Auto Other									
21. Employer of subscriber 2.J. Employment status 24. If patient is covered under Medicare, complete the following: Medicare Part A: Yes No Medicare Part B: Yes No 28. If patient is covered under Medicare, complete the following: Medicare Part A: Yes No Medicare Part B: Yes No 29. Diagnosis -3A. Describe illness, injury, or symptoms requiring treatment and onset date of symptoms or injury. 38. Was patient's treatment due to a work-related accident or condition? Yes No 30. Complete for care related to accidental injuries Location: At home Auto Other Time of accident									
Active employee Active employee				2.J. Employment		mplovment st			
Effective date									
3. Diagnosis — 3A. Describe illness, injury, or symptoms requiring treatment and onset date of symptoms or injury. 3B. Was patient's treatment due to a work-related accident or condition? □ Yes □ No 3C. Complete for care related to accidental injuries Date of accident	2K. If patient is covered under	r Medicare, complete the follo	wing:	Medicare Part	A: 🗆	∕es ⊡No N	ledicare Part B:	□ Yes □No	
3B. Was patient's treatment due to a work-related accident or condition? □ Yes □ No 3C. Complete for care related to accidental injuries Date of accident				Effective date E			ffective date		
3B. Was patient's treatment due to a work-related accident or condition? □ Yes □ No 3C. Complete for care related to accidental injuries Date of accident	2 Diagnosia 24 Dessrib			two other out and		data of arment			
3C. Complete for care related to accidental injuries Date of accident Location: □ At home □ Auto □ Other	3. Diagnosis — 3A. Describe	e inness, injury, or symptoms re	quinng		onser	uate of sympto	onis or injury.		
3C. Complete for care related to accidental injuries Date of accident Location: □ At home □ Auto □ Other	3B. Was patient's treatment d	ue to a work-related accident o	or condi	tion? 🗆 Yes 🗆] No				
Time of accident If the accident was caused by someone else, attach a statement describing the accident. 4. Charges Use a separate line to list each type of service or provider and attach itemized bills for all services. 4A. Name and address of provider making charge 4B. Type of provider 4C. Description of service 4D. Dates of service or purchase 4B. Type of provider making charge 4B. Type of provider 4C. Description of service 4D. Dates of service or purchase 4E. Charges 5. Payee Select one of the following payment options: Option A. Make payment to subscriber; provider has been paid. Select your payment preference: Check - US Dollar Electronic Funds Transfer - Currency on itemized bill(s) If you want to receive an electronic funds transfer provide the following: Subscriber name as it appears on bank account: Bank name: Bank name:	-								
4. Charges — Use a separate line to list each type of service or provider and attach itemized bills for all services. 4A. Name and address of provider making charge 4B. Type of provider 4C. Description of service 4D. Dates of service or purchase 4E. Charges or purchase 4. Name and address of provider making charge 4B. Type of provider 4C. Description of service 4D. Dates of service or purchase 4E. Charges or purchase 4. Name and address of provider making charge 4B. Type of provider 4C. Description of service 4D. Dates of service or purchase 4E. Charges or purchase 5. Payee — Select one of the following payment options: Option A.	Date of accident	L	_ocation	: 🗆 At home	🗆 Auto	o □ Other			
4A. Name and address of provider making charge 4B. Type of provider 4C. Description of service 4D. Dates of service or purchase 4E. Charges	Time of accident	ime of accident If the accident was caused by someone else, attach a statement describing the accident.							
4A. Name and address of provider making charge 4B. Type of provider 4C. Description of service 4D. Dates of service or purchase 4E. Charges	4. Charges — Use a separa	ate line to list each type of ser	rvice or	provider and a	ttach it	temized bills f	or all services.		
 5. Payee — Select one of the following payment options: Option A. Make payment to subscriber; provider has been paid. Select your payment preference: Check - US Dollar Electronic Funds Transfer - US Dollar Electronic Funds Transfer - Currency on itemized bill(s) If you want to receive an electronic funds transfer provide the following: Bank name: Bank's Physical Address:	4A. Name and address of 4B. Type of provider		-			4D. D	4D. Dates of service 4E. Charges		
 5. Payee — Select one of the following payment options: Option A. Make payment to subscriber; provider has been paid. Select your payment preference: Check - US Dollar Electronic Funds Transfer - US Dollar Electronic Funds Transfer - Currency on itemized bill(s) If you want to receive an electronic funds transfer provide the following: Bank name: Bank's Physical Address:									
Option A. Make payment to subscriber; provider has been paid. Select your payment preference: Check – US Dollar Electronic Funds Transfer – Currency on itemized bill(s) If you want to receive an electronic funds transfer provide the following: Bank name: Bank name: Subscriber name as it appears on bank account: Bank name: Bank name: Bank's Physical Address: Account # /IBAN: Routing # / ABA / BIC / SWIFT: Option B. Make payment to provider (hospital, doctor), if appropriate. Please complete and sign to authorize direct payment to provider. I, the undersigned, authorize and request payment for benefits due herein to be made to the following provider of services, if such direct payment is deemed appropriate by the subscriber's Blue Cross and Blue Shield company:									
Account # /IBAN:Routing # / ABA / BIC / SWIFT: Option B. Make payment to provider (hospital, doctor), if appropriate. Please complete and sign to authorize direct payment to provider. I, the undersigned, authorize and request payment for benefits due herein to be made to the following provider of services, if such direct payment is deemed appropriate by the subscriber's Blue Cross and Blue Shield company:	Option A. I Make payment Select your payment preference: If you want to receive an electronic f	to subscriber; provider has b Check – US Dollar Electronic F unds transfer provide the following:	een pai ⁻ unds Tran	sfer – US Dollar					
Option B. D Make payment to provider (hospital, doctor), if appropriate. Please complete and sign to authorize direct payment to provider. I, the undersigned, authorize and request payment for benefits due herein to be made to the following provider of services, if such direct payment is deemed appropriate by the subscriber's Blue Cross and Blue Shield company:	Bank's Physical Address:								
I, the undersigned, authorize and request payment for benefits due herein to be made to the following provider of services, if such direct payment is deemed appropriate by the subscriber's Blue Cross and Blue Shield company:	Account # /IBAN:		Routing # / ABA / BIC / SWIFT:						
I, the undersigned, authorize and request payment for benefits due herein to be made to the following provider of services, if such direct payment is deemed appropriate by the subscriber's Blue Cross and Blue Shield company:	Option B. 🗆 Make payment to	provider (hospital, doctor), if an	opropriat	te. Please comp	lete and	d sign to autho	rize direct pavm	ent to provider.	
Name of provider Date Date	I, the undersigned, authorize and rec	quest payment for benefits due herein		-		-		-	
	Name of provider Signature of subscriber or spouse						Da	te	

6. Signature — I certify the above is complete and correct and that I am claiming benefits only for charges incurred by the patient named above. Authorization is hereby given to any provider of service, that participated in any way in the patient's care, to release to the subscriber's Blue Cross and Blue Shield company and its business associates in any country any medical or other personal information that they deem necessary to provide service or adjudicate this claim, recognizing that applicable law concerning personal information may differ among countries. Authorization is also given to the subscriber's Blue Cross and Blue Shield company and 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.

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.