International Claim Form

BlueCross BlueShield Global. | Core

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

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

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

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

Section 1: Patient information

1A. Member ID (Include all letters and numbers as shown on your Blue Cross Blue Shield identification card.)		
1B. Patient's name (First, middle initial, last)	1C. Patient's date of birth (MMDDYYYY)	1D. Patient's gender ☐ Male ☐ Female
1E. Name of subscriber (First, middle initial, last)	1F. Subscriber's date of birth (MMDDYYYY)	1G. Patient's relation to subscriber ☐ Self ☐ Spouse ☐ Child
1H. Subscriber's current mailing address (Street, city, state, and country or ZIP code)	1I. Patient's email address	

Section 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 ☐ Family ☐ Individual	2C. Effective date (MMDDYYYY)	2D. Termination date (MMDDYYYY)	2E. Policy or identification number of other coverage
2F. Type of coverage Medical: ☐ Yes ☐ No Hospital: ☐ Yes ☐ No Mental illness: ☐ Yes ☐ No		2G. Name of subscriber	2H. Subscriber's date of birth (MMDDYYYY)
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 Effective date (MMDDYYYY): Medicare Part B: ☐ Yes ☐ No Effective date (MMDDYYYY):			

Section 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 (MMDDYYYY): Time of accident: _____ ☐ am ☐ pm
Location: ☐ At home ☐ Auto ☐ Other: _____ If the accident was caused by someone else, attach a statement describing the accident.

Section 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

Section 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:

Subscriber name as it appears on bank account: _____ 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:

Name of provider: _____ Signature of subscriber or spouse: _____ Date:

Section 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.

Signature of subscriber or patient	Printed name	Date (MMDDYYYY)
X		

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:

Section 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).

Section 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.

Section 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.

Section 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.

Section 6: Signature

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

Disclosure statement

For your protection California law requires the following to appear on this form. Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

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