BlueCross® BlueShield®

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

BlueCard Worldwide® International Claim Form

UNITED

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

Send completed form to: BlueCard Worldwide Service Center or ihc@allianzassistance.com
P.O. Box 72017
Richmond, VA 23255-2017 USA

If you have questions about this form, call 800-535-9825.

1. Patient Information — 1A. Alpha prefix Identification number

Copy this from your Blue Cross Blue Shield identification card.

1B. Patient's name (First, middle initial, last)	1C. Patient's date of birth MM/DD/YYYY / /	1D. Patient's sex ☐ Male ☐ Female
1E. Name of subscriber (First, middle initial, last)	1F. Subscriber's date of birth MM/DD/YYYY / /	1G. Patient's relationship to subscriber ☐ Self ☐ Spouse ☐ Child

1H. Subscriber's current mailing address (Street, city, state, and country or ZIP code)

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 MM/DD/YYYY / /	2D. Termination date MM/DD/YYYY / /	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. Date of birth MM/DD/YYYY / /
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 _____ Medicare Part B: ☐ Yes ☐ No 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 _____ Location: ☐ At home ☐ Auto ☐ Other _____

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	4E. Charges

5. Payee — Select one of the following payment options:

5A. ☐ **Make payment to subscriber; provider has been paid.**

1. **Currency** – Please check your preference for payment: ☐ **Currency on itemized bill(s)** ☐ **U.S. dollars**

2. **Payment Method** – Please select your preference for how to receive your payment: ☐ **Check** (Provide current telephone number) _____

☐ **Bank Wire.** If you want to receive a bank wire provide the following:

Subscriber name as it appears on bank account: _____ Bank name: _____

Bank's Physical Address: _____ Account #: _____

ABA# _____ *International Bank Account (IBAN) #: _____

*Bank Identifier Code (BIC/SWIFT) _____ ** Required for bank wires to European Union countries.*

5B. ☐ **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 Blue Cross and Blue Shield:

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

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 Plan 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 Plan 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 Plan's Notice of Privacy Practices.

Signature of subscriber or patient _____ Date _____

General Information

The BlueCard Worldwide 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 filing instructions for other claim types (e.g., dental, prescription drugs, etc.) contact your Blue Cross and Blue Shield Plan.**

The International Claim Form must be completed for each patient in full, and accompanied by fully itemized bills. It is not necessary for you to provide an English translation or convert currency.

Since the claim cannot be returned, please be sure to keep photocopies of all bills and supporting documentation for your personal records.

International Claim Form Instructions

Please complete all items on the claim form. If the information requested does not apply to the patient, indicate N/A (Not Applicable). Special care should be taken when completing the following items:

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 here the bills that are being included on this claim. Although itemized bills must also be submitted, your listing will enable us to process the claim more quickly and accurately. If additional space is needed for listing charges, 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 — bills must be itemized to show a separate charge for each service. If the bill has already been paid, please indicate the date it was paid.

5. Payee

5A. Make payment to subscriber, designation of currency and payment method – 1) Indicate whether you want to be paid in the currency reflected on the bill(s) or in U.S. dollars and if you want to receive payment via check or bank wire. 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 will typically charge a flat fee or percentage-based fee to receive a wire. You may want to investigate fees charged by your bank prior to requesting a wire since you will be responsible for any such fees.

2) You must include the following information on this form: your full name (initials are not acceptable), your physical address (payments cannot be sent to a P.O. box). For wire payments, subscriber's name as it appears on the bank account, the bank's name and physical address (payments cannot be wired to a P.O. box), account number, ABA number. Please provide a copy of a voided check or deposit slip so that the bank information can be validated. Additionally, for wire payments to European Union countries, you must provide the International Bank Account Number (IBAN) and Bank Identifier Code (BIC/SWIFT). For checks to be sent by express mail, you must provide a current telephone number.

5B. Authorization for payment to provider – complete item 5B if you prefer that benefits be paid directly to the provider of service. Direct payment to the provider is at the discretion of Blue Cross and Blue Shield, except where required by law.

6. Signature

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

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

This completed claim form, together with itemized bills and supporting documentation, should be submitted to:

BlueCard Worldwide Service Center or ihc@allianzassistance.com
P.O. Box 72017
Richmond, VA 23255-2017 USA