Section 7. Filing a claim for covered services

How to claim benefits

To obtain claim forms, visit our Web site at www.AFSPA.org/FSBP. To obtain claims filing advice or answers about our benefits, contact us by mail at **Foreign Service Benefit Plan**, 1716 N Street, NW, Washington, DC 20036-2902, by phone at 202-833-4910 (members) or 202-833-5751 (health care providers), fax at 202-833-4918, or secure e-mail through our Web site at www.AFSPA.org/FSBP (click on the “Ask AFSPA” tab and then "FSBP").

In most cases, providers and facilities file claims for you. Your physician must file on the form CMS-1500, Health Insurance Claim Form. Your facility will file on the UB-04 form.

When you must file a claim – such as for non-PPO providers or when another group health plan is primary – submit it on the CMS-1500 or a claim form that includes the information shown below. Claims from foreign providers do not need to be filed on a CMS-1500 (see *Foreign Claims* on next page). Bills and receipts should be itemized and show:

- Name of patient, date of birth and relationship to enrollee;
- Plan identification number of the enrollee;
- Name and address of person or firm providing the service or supply;
- Dates that services or supplies were furnished;
- Diagnosis;
- Valid medical or dental code and/or description of each service or supply; and
- The charge for each service or supply.

Note: Canceled checks, cash register receipts, or balance due statements are not acceptable substitutes for itemized bills. The Plan cannot accept a claim as an e-mail attachment, except as described above (and also in detail on the next page under *Foreign claims*) using our secure electronic method.

In addition:

- Generally, you need to fill out only one claim form per year. You should fill out a claim form if you submit a claim due to accidental injury, you have changed your address, or if the member’s other insurance/Medicare status has changed.
- You must send a copy of the explanation of benefits (EOB) form you received from any primary payor (such as the Medicare Summary Notice (MSN)) with your claim. See Section 9 for Medicare claims.
- Bills for private duty nursing care must show that the nurse is a Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.). You also should include the initial history and physical, treatment plan indicating expected duration and frequency from your attending physician and the nurse's notes from the nurse.
- Claims for rental or purchase of durable medical equipment must include the purchase price, a prescription and a statement of medical necessity including the diagnosis and estimated length of time needed.
- Claims for physical, occupational, and speech therapy must include an initial evaluation and treatment plan indicating length of time needed for therapy and progress (therapy) notes for each date of service from the therapist.
- Claims for dental services must include a copy of the dentist’s itemized bill (including the information required above) and the dentist’s Federal Tax ID Number. We do not have separate dental claim forms.
- Claims for alternative treatment services must include a copy of the provider’s itemized bill (including the information required above) and the provider’s Federal Tax ID Number (only if a United States provider).

Foreign Claims

The **Foreign Service Benefit Plan** pays claims for providers outside the 50 United States at the same PPO coinsurance rate as PPO providers in the 50 United States.

If you are posted outside the 50 United States and both the Medical and Health Program of the Department of State – Office of Medical Services (OMS) and we cover you, submit claims to us as described on the previous page or as directed by OMS, through your Administrative Office.

If the Medical and Health Program of the Department of State does not cover you, you should submit claims directly to us as described on the previous page.

You may include an English translation (not required) and a currency exchange rate (recommended). We will translate claims and convert them to U.S. Dollars using the exchange rate applicable at the time the expense was incurred if you do not supply us with a currency conversion rate. You do not need to file foreign claims on CMS-1500 or UB-04 forms.

We have **special direct billing arrangements** with hospitals in several countries, including Brazil, China, Colombia, Germany, Italy, Korea, Panama and Russia. We also have a fast track payment process if you reside in Korea. In addition, overseas Seventh-day Adventist Hospitals and Clinics participate in our special billing arrangement. Please contact us for more information on these arrangements if you are in these locations.

The Plan provides a secure electronic method for you to submit claims to us via the Internet from overseas locations. Visit our Web site (www.AFSPA.org/FSBP), click on the "Ask AFSPA" tab and then "FSBP". You can attach a scanned copy of your claim (as a PDF) to an e-mail message you send to us through this secure method. We designed this secure process to eliminate the lengthy mail time from your post to our office and to protect your private health information (PHI). Also, you may correspond with us via secure e-mail through this process. In addition, you may fax us your claims from overseas. Our special fax number is 202-464-4508.

If you prefer, you may send your claim with proper documentation via mail to:

Foreign Service Benefit Plan

1716 N Street, NW

Washington, DC 20036-2902

Do not send your claims in care of Department of State (Pouch Mail). It will delay your claim substantially.

Plan telephone numbers: 202-833-4910 (members); 202-833-5751 (health care providers)

Urgent care claims procedures

If you have an urgent care claim, please contact our Customer Service Department at **Foreign Service Benefit Plan,** 1716 N Street, NW, Washington, DC 20036-2902, by phone at 202-833-4910 (members), fax at 202-833-4918, or secure e-mail through our Web site at www.AFSPA.org/FSBP (click on the "Ask AFSPA" tab and then "FSBP"). Urgent care claims must meet the definition found in Section 10 of this brochure, and most urgent care claims will be claims for access to care rather than claims for care already received. We will notify you of our decision not later than 72 hours after we receive the claim as long as you provide us with sufficient information to decide the claim. If you or your authorized representative fails to provide sufficient information to allow us to make a decision, we will inform you or your authorized representative of the specific information necessary to complete the claim not later than 72 hours after we receive the claim and a time frame for our receipt of this information. We will decide the claim within 48 hours of (i) receiving the information or (ii) the end of the time frame, whichever is earlier.

We may provide our decision orally within these time frames, but we will follow up with a written or electronic notification within three days of oral notification.

Concurrent care claims procedures

A concurrent care claim involves care provided over a period of time or over a number of treatments. We will treat any reduction or termination of our pre-approved course of treatment as an appealable decision. If we believe a reduction or termination is warranted we will allow you sufficient time to appeal and obtain a decision from us before the reduction or termination takes effect.

If you request an extension of an ongoing course of treatment at least 24 hours prior to the expiration of the approved time period and this is also an urgent care claim, then we will make a decision within 24 hours after we receive the claim.

Pre-service claims procedures

As indicated in Section 3, certain care requires Plan approval in advance. We will notify you of our decision within 15 days after the receipt of the pre-service claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you before the expiration of the original 15-day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.

If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60 days from the receipt of the notice to provide the information.

If you fail to follow these pre-service claim procedures, then we will notify you of your failure to follow these procedures as long as (1) your request is made to our customer service department and (2) your request names you, your medical condition or symptom, and the specific treatment, service, procedure, or product requested. We will provide this notice within five days following the failure or 24 hours if your pre-service claim is for urgent care. Notification may be oral, unless you request written correspondence.

Post-service claims procedures

We will notify you of our decision within 30 days after we receive your post-service claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you before the expiration of the original 30-day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.

If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60 days from the receipt of the notice to provide the information.

Records

Keep a separate record of the medical expenses of each covered family member as deductibles and maximum allowances apply separately to each person. Save copies of all medical bills, including those you accumulate to satisfy a deductible. In most instances they will serve as evidence of your claim.

We will provide you with a record of expenses you submit and benefits we paid for each claim that you file (explanation of benefits (EOB)). You are responsible for keeping these. We will not provide duplicate or year-end statements. If you need duplicate copies, refer to Section 5 (h), *Special features* under *Web based customer service.*

Deadline for filing your claim

Send us all of the documents for your claim as soon as possible. You must submit the claim within 2 years from the date you incur the expense. We can extend this deadline if you were prevented from filing your claim timely by administrative operations of Government or legal incapacity, provided you file the claim as soon as reasonably possible. Once we pay benefits, there is a three-year limitation on the reissuance of uncashed checks.

When we need more information

Please reply promptly when we ask for additional information. We may delay processing or deny benefits for your claim if you do not respond. Our deadline for responding to your claim is stayed while we await all of the additional information needed to process your claim.

Authorized Representative

You may designate an authorized representative to act on your behalf for filing a claim or to appeal claims decisions to us. For urgent care claims, a health care professional with knowledge of your medical condition will be permitted to act as your authorized representative without your express consent. For the purposes of this section, we are also referring to your authorized representative when we refer to you.