BlueCard Worldwide® International Claim Form



Date

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

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 claims@bluecardworldwide.com

Signature of subscriber or patient

P.O. Box 261630
Miami, FL 33126 USA

1. Patient Information — 1A. Alpha prefix Identification nur	mber Copy this from your	Blue Cross Blu	ue Shield identifica	tion card.		
1B. Patient's name (First, middle initial, last)	1C. Patient's date of birth		1D. Patient's sex ☐ Male ☐ Female			
IE. Name of subscriber (First, middle initial, last) 1F. Subscriber		bscriber's date of birth		1G. Patient's relationship to subscriber		
	MM/DD/YYYY /	/	Self Spou	ıse 🔲 Ch	ild	
1H. Subscriber's current mailing address (Street, city, state, and country of	or ZIP code)		11. Patient's e	-mail ad	dress	
2. Other Health Insurance — Is the patient covered under of	ther health insurance, inclu	ıding Medic	are A or B?	Yes 🗌	No	
2A. Name and address of other insuring company						
	1 1 1		or identification number			
Family Individual MM/DD/YYYY / / MM/DI	. , , , , , , , , , , , , , , , , , , ,	other cove				
,, , , , , , , , , , , , , , , , , , ,	Name of subscriber		2H. Date of bi	rth /	,	
I I						
2I. Employer of subscriber	2J. Employment Active employee		_			
2K. If patient is covered under Medicare, complete the following:	Medicare Part A: Yes No	<u> </u>	dicare Part B: Ye	s DNo		
in pulioni is develou unuel medicule, complete the following.	Effective date		ective date			
3. Diagnosis — 3A. Describe illness, injury, or symptoms requiri	ng treatment and onset dat	te of sympt	oms or injury.			
BB. Was patient's treatment due to a work-related accident or conc	lition? 🗌 Yes 🔲 No					
3C. Complete for care related to accidental injuries		_				
Date of accident Locatio	n: At home Auto	Other				
Time of accident If the acc	ident was caused by someone else	e, attach a state	ement describing tl	ne accident	t.	
4. Charges — Use a separate line to list each type of service of	or provider and attach item	ized bills fo	or all services.			
4A. Name and address of 4B. Type of provider 4C. D provider making charge	escription of service		tes of service purchase	4E. Chai	rges	
5. Payee — Select one of the following payment options: 5A. Make payment to subscriber; provider has been paid. Currency - Please check your preference for payment: Currency on itemized to payment Method - Please select your preference for how to receive your payment Bank Wire. If you want to receive a bank wire provide the following: Subscriber name as it appears on bank account:	nent: Check (Provide current t					
Bank's Physical Address:						
Account # / IBAN:	Routing # / ABA / BIC / SW	IFT:				
5B. Make payment to provider (hospital, doctor), if appropriate, the undersigned, authorize and request payment for benefits due herein to be many Blue Cross and Blue Shield:	•			-		
Name of provider Signature of subscribe	r or spouse		Date			
6. Signature — I certify the above is complete and correct and that I am clair nereby given to any provider of service, that participated in any way in the patient's associates in any country any medical or other personal information that they deer aw concerning personal information may differ among countries. Authorization i associates in any country to collect, use or release any medical or other personal otherwise described in such Blue Cross and Blue Shield Plan's Notice of Privacy F	care, to release to the subscriber's n necessary to provide service or s also given to the subscriber's B information that they deem nece	s Blue Cross an adjudicate this lue Cross and	nd Blue Shield Plan claim, recognizing Blue Shield Plan a	and its but that applic nd its busi	siness cable iness	

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 other claim types (e.g., dental, prescription drugs), contact your Blue Cross and Blue Shield Plan 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, 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

- 5A. Make payment to subscriber, designation of currency and payment method 1) 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 investigate fees charged by your bank prior to requesting a wire since you will be responsible for any such fees.
- 2) For wire payments, provide the bank's physical address (not a P.O. Box). For the account number/IBAN and routing number (ABA / BIC / SWIFT), please contact your bank. Please provide a copy of a voided check or deposit slip so that the bank information can be validated.
- **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.

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.