BlueCross® BlueShield® Blue Crescent℠

Federal Employee Program
OVERSEAS MEDICAL CLAIM FORM

A. ENROLLMENT CODE 1 | **IDENTIFICATION NUMBER** R

Please see the instructions on the reverse side of this form before completing
PLEASE TYPE OR PRINT.

PATIENT INFORMATION

If the patient's last name is different from the subscriber's, please attach a statement explaining the relationship

B. PATIENT'S NAME (First, Middle Initial, Last)

C. PATIENT DATE OF BIRTH Month Day Year

D. PATIENT'S GENDER Male ☐ Female ☐

E. NAME OF SUBSCRIBER POLICY HOLDER (First, Middle Initial, Last)

F. SUBSCRIBER'S DATE OF BIRTH Month Day Year

G. PATIENT'S RELATIONSHIP TO SUBSCRIBER Self ☐ Spouse ☐ Dependent ☐

H. SUBSCRIBER'S CURRENT MAILING ADDRESS (Street, City, State, and Country or ZIP)

I. Email Address

OTHER HEALTH INSURANCE

Is the patient covered under other health insurance? If yes, complete items A through J below. ( ) Yes ( ) No

A. Name and Address of Insuring Company

B. Type of Policy ( ) Family ( ) Individual

C. Effective Date Month Day Year

D. Termination Date Month Day Year

E. Policy or Identification Number of Other Coverage

F. Type of Coverage
Medical ( ) Yes ( ) No
Dental ( ) Yes ( ) No

G. Name of Policy Holder

H. Date of Birth Month Day Year

I. Employer of Policy Holder

J. Employment Status ( ) Active Employee ( ) Retired Employee

MEDICARE

Complete this section regardless of the patient's age

If you are covered by Medicare HMO/Prepaid Plan, please leave sections A and B blank

A. Medicare Part A ( ) Yes ( ) No
Effective Date _____

B. Medicare Part B ( ) Yes ( ) No
Effective Date _____

C. Medicare HMO/ Prepaid Plan ( ) Yes ( ) No
Effective Date

D. Medicare ID #

E. Is the subscriber an active Federal Employee? ( ) Yes ( ) No

F. Is the patient an active Federal Employee? ( ) Yes ( ) No

G. End Stage Renal Patients,
Please indicate the beginning date of renal treatment.
Begin Date _____

DIAGNOSIS

A. Describe reason for visit: routine care, illness, injury, or symptoms requiring treatment (e.g., cough, sore throat).

B. Was the patient's treatment due to a work-related accident or condition? ( ) Yes ( ) No

C. Complete for care related to accidental injuries.
Date of accident _____ Time of Accident _____ Location ( ) Home ( ) Auto ( ) Other _____

CHARGES and PAYMENT INFORMATION

Please list below: Begin and End date for charges that are being claimed.

A. Begin Date _____

B. End Date _____

C. Total Charges _____

D. Number of Itemized Bills _____

MEMBER PAYMENT INFORMATION

Select one of the following payment options

Payment Method: ( ) Check ( ) Bank Wire

Requested Currency: ( ) US Dollars
( ) Currency on Bills

A. Bank Wire Information

Please complete if you selected Bank Wire Payment:

Name on Bank Account _____

Bank Name _____

Bank Physical Address _____

State Where Account was Opened _____

Routing Number (ABA/SWIFT)

Account Number (local bank/IBAN)

B. Authorization for Assignment of Benefits
(Benefits can only be assigned to one provider for each claim)

I, the undersigned, authorize and request CareFirst BlueCross Blue Shield to make payment for benefits due herein to:

Provider Name

Provider Address

Signature of Subscriber or Spouse Date

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, which participated in any way in the patient's care, to release to CareFirst BlueCross BlueShield, any medical information which they deem necessary to adjudicate this claim. **Submission acts as signature for e-Claims**

Signature of Subscriber or Patient Date Home Phone Number

FEDERAL EMPLOYEE PROGRAM OVERSEAS MEDICAL CLAIM FORM

PLEASE USE THE RETAIL PRESCRIPTION DRUG OVERSEAS CLAIM FORM FOR ALL PRESCRIPTION DRUGS PURCHASED AT PHARMACIES OUTSIDE OF THE UNITED STATES, PUERTO RICO, AND THE U.S. VIRGIN ISLANDS

GENERAL INFORMATION

This Overseas Medical Claim Form is to be used to submit a claim for benefits for covered services received outside the United States, Puerto Rico, and the U.S. Virgin Islands. Please complete a separate claim form for each patient and remember to file all claims by December 31 of the calendar year after the one in which the covered care or service was provided.

The Overseas Medical Claim Form must be completed in full, and accompanied by fully itemized bills. Please be sure to keep photocopies of all bills and supporting 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

OVERSEAS MEDICAL 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:

OTHER HEALTH INSURANCE – If the patient holds other insurance coverage, please complete items A through J 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 Policy Holder 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.

MEDICARE – Medicare benefits are often limited for care provided outside the United States and its territories. Please refer to your Medicare handbook. However, please complete item 3 regardless of the patient's age.

DIAGNOSIS – Describe reason for visit, illness, injury, or symptoms requiring treatment, e.g. cough, sore throat.

CHARGES – Please list here the number of bills that are being included on this claim. Please attach itemized bills for all services. Please list the beginning date and the end date of service.

A. **Begin Date-** The first date of service for which benefits are being claimed
B. **End Date-** The last date of service for which benefits are being claimed
C. **Total Charges-** The total amount being claimed for all bills attached.
D. **Number of Itemized Bills Attached-** Total number of itemized bills for all services being claimed.

MEMBER PAYMENT INFORMATION – **Make payment to subscriber, designation of currency and payment method** – 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.

BANK WIRE INFORMATION – You must include the following information on this form: your full name (initials are not acceptable) and 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 (ABA/SWIFT). For checks to be sent by express mail, you must provide a current telephone number.

AUTHORIZATION FOR ASSIGNMENT OF BENEFITS – Complete this item if you prefer that benefits be paid directly to the provider of service.

SIGNATURE – The Overseas Medical Claim Form must be signed and dated by the Policy Holder, spouse, or the patient.
Submission acts as signature for e-Claims

THIS COMPLETED CLAIM FORM, TOGETHER WITH ITEMIZED BILLS AND SUPPORTING DOCUMENTATION, SHOULD BE SUBMITTED TO:

Federal Employee Program (FEP) Overseas Claims, PO Box 261570, Miami, FL 33126

YOU CAN ALSO FAX YOUR CLAIMS TO EITHER 1-888-650-6525 OR 410-781-7637
DEPENDING ON THE LOCATION THAT YOU FAX FROM, YOU MAY NOT NEED TO ADD THE 1 IN FRONT OF THE 888 FAX NUMBER.

ADDITIONAL CLAIM FORMS and FAX DIALING INSTRUCTIONS AVAILABLE ON www.fepblue.org. OR BY CALLING 1-888-999-9862