# **BlueCard Worldwide®** International Claim Form



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 <u>claims@bluecardworldwide.com</u> P.O. Box 261630

P.U. BOX 261630

Miami, FL 3	3126 USA						
<b>1. Patient Information</b> — 1A. Alp	ha prefix Identificati	on number Copy	this from	your Blue Cro	oss Blue Shield identif	ication card.	
L	_LL LLL						
1B. Patient's name (First, middle initial, las	1C. Patient's date of birth				1D. Patient's sex		
1E. Name of subscriber (First, middle ini	1F. Subscrib	1F. Subscriber's date of birth			1G. Patient's relationship to subscriber		
		MM/DD/YYYY	/	/	□ Self □ Sp		hild
1H. Subscriber's current mailing add	ress (Street, city, state, and o	country or ZIP code)	1	, <u>,</u>	11. Patient's	e-mail ad	dress
2. Other Health Insurance – Is	the patient covered ur		irance, i	including N	Medicare A or B?	□ Yes □	No
2A. Name and address of other insu							
2B. Type of policy     2C. Effective date       □ Family     □ Individual					. Policy or identification number other coverage		
2F. Type of coverage Hospital:	2G. Name of subscriber			2H. Date of birth			
Medical: Yes No Mental illness					MM/DD/YYYY / /		
2I. Employer of subscriber			mploymen ive employee	: <b>status</b> □ Retired employee			
2K. If patient is covered under Medic	are, complete the follo	wing: Medicare Part A:	☐ Yes	□ No	Medicare Part B:	Yes ⊡No	
		Effective date			Effective date		-
<b>3. Diagnosis</b> — 3A. Describe illnes	s, injury, or symptoms	requiring treatment an	d onse	t date of sy	ymptoms or injur	<b>y</b> .	
3B. Was patient's treatment due to a v	work-related accident c	or condition?  Yes	No				
3C. Complete for care related to acci							
Date of accident	ocation: 🗆 At home	: 🗆 At home 🗆 Auto 🗆 Other					
Time of accident	<sup>f</sup> the accident was caused b	ccident was caused by someone else, attach a statement describing the accident.					
4. Charges — Use a separate line	to list each type of se	rvice or provider and	attach	itemized b	ills for all services		
4A. Name and address of 4B. Type of provider provider making charge		4C. Description of service		4	D. Dates of service or purchase		
5. Payee — Select one of the folic	wing payment option						
5A.  Make payment to subscriber;	• · · ·						
1. Currency – Please check your preference for							
2. Payment Method – Please select your prefe			ovide cur	rent telephor	ne number)		
Bank Wire. If you want to receive a bank Subscriber name as it appears on bank acco			Bar	nk name:			
Bank's Physical Address:							
		Routing # / ABA / BIC / SWIFT:					
5B.  Make payment to provider (ho							
I, the undersigned, authorize and request payr by Blue Cross and Blue Shield:	• • • •			-		-	
Name of provider	ubscriber or spouse			D	ate		

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.

# **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.