International Claim Form

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

BlueCross BlueShield Global | Core

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

Send completed form and documentation to:
or online at www.bcbsglobalcore.com

Service Center
P.O. Box 2048
Southeastern, PA 19399

or claims@bcbsglobalcore.com

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)		1I. Patient's e-mail address

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:

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

Select your payment preference: **Check** – US Dollar **Electronic Funds Transfer** – US Dollar **Electronic Funds Transfer** – Currency on itemized bill(s)

If you want to receive an electronic funds transfer provide the following:

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

Bank's Physical Address: _____

Account # /IBAN: _____ Routing # / ABA / BIC / SWIFT: _____

Option B. 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 the subscriber's Blue Cross and Blue Shield company:

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 company 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 company 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 company's Notice of Privacy Practices.

Signature of subscriber or patient _____ Date _____

General Information

- The Blue Cross Blue Shield Global Core 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 Company 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 (test results, x-rays, etc.), 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 BE TAKEN 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

Option A. Make payment to subscriber, designation of currency and payment method — 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 research fees charged by your bank prior to requesting a wire since you will be responsible for any such fees.

For an electronic funds transfer, provide the bank's physical address where the account was opened (not a P.O. Box). Please provide a copy of a voided check or deposit slip so that the bank information can be validated.

Option B. Authorization for payment to provider — complete option B if you prefer that benefits be paid directly to the provider of service. Direct payment to the provider is at the discretion of your Blue Cross and Blue Shield Company, 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.

Capital BLUE

Capital BlueCross is an Independent Licensee of the BlueCross BlueShield Association

NONDISCRIMINATION AND FOREIGN LANGUAGE ASSISTANCE NOTICE

Capital BlueCross and its family of companies comply with applicable federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. Capital BlueCross does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Capital BlueCross provides free aids and services to people with disabilities or whose primary language is not English, such as:

- ✓Qualified sign language interpreters
- ✓Written information in other formats (large print, audio, accessible electronic format, other formats)
- ✓Qualified interpreters, and information written in other languages

If you need these services, call 800.962.2242 (TTY: 711).

If you believe that Capital BlueCross has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age disability, or sex, you can file a grievance with our Civil Rights Coordinator. You can file a grievance in person or by mail, fax, or email at

Capital BlueCross
P.O. Box 779880 Harrisburg, PA 17177-9880
800.417.7842 (TTY: 711), fax, 855.990.9001
CRC@capbluecross.com

If you need help filing a grievance, our Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW., Room 509F, HHH Building
Washington, D.C. 20201
Toll-free 800.368.1019, 800.537.7697 (TDD)
Complaint forms are available at https://www.hhs.gov/ocr/office/file/index.html.

Language assistance

To talk to an interpreter in your language at no cost, call 800.962.2242 (TTY: 711).
Para hablar con un intérprete de forma gratuita, llame al 800.962.2242 (TTY: 711).
欲免费用本国语言洽询传译员，请拨电话 800.962.2242 (TTY: 711).
Để nói chuyện với thông dịch viên bằng ngôn ngữ của quý vị không phải mất phí, xin gọi 800.962.2242 (TTY: 711).
Для бесплатного разговора с переводчиком на своем языке, позвоните по тел.: 800.962.2242 (TTY: 711).
Fa koschdefrei schwetze mit me dolmetscher in deinre Schrooch, ruf 800.962.2242 uff (TTY: 711).
무료 전화 통역 서비스 800.962.2242 (TTY: 711).
Per parlare con un interpete nella vostra lingua gratis, chiami 800.962.2242 (TTY: 711)
للتحدث مجانًا إلى مترجم للغتك، يرجى الاتصال بـ 800.962.224
(الهاتف النصي: 711)
Pour parler à un interpréter dans votre langue sans charges, téléphoner à 800.962.2242 (TTY: 711).
Um in Ihrer Sprache gebührenfrei mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 800.962.2242 an (TTY: 711).
ફ્રભાષીયા જોડે વાત કરવા, 800.962.2242 (TTY: 711) પર ફોન કરો.
Aby porozmawiac z tlumaczem w jezyku polskim, prosze zadzwonic na numer darmowy telefonu 800.962.2242 (TTY:711)
Pou pale avèk yon entèprèt nan lang ou grastis, rele nan 800.962.2242 (TTY: 711).
ដើម្បីនិយាយជាមួយអ្នកបកប្រែផ្ទាល់មាត់ជាភាសារបស់អ្នកដោយមិនគិតថ្លៃ សូមហៅទៅកាន់ 800.962.2242 (TTY: 711)
Para falar com um intérprete em seu idioma de graça, ligue para 800.962.2242 (TTY: 711).