

Medical Expense

Claim Form and Instructions – Outside of the U.S.



To complete your claim form, make sure you fill in everything in sections 1–6. And don't forget to sign the form. Instructions for sending the form are on the last page. Or, for a quicker and easier way, you can use our eClaims tool using the Member Portal or BCBS Global Solutions™ mobile app.

1 Patient Information

Member ID *(Please enter the Member ID number as shown on card)* _____

Patient's Name *(First name, last name)* _____

Patient's Date of Birth *(MM/DD/YYYY)* _____ Patient's Sex Recorded at Birth Male Female

Name of Primary Insured *(First name, last name)* _____

Primary Insured's Date of Birth *(MM/DD/YYYY)* _____

Patient's Relationship to Primary Insured Self Spouse Child

Employer of Primary Insured _____

Primary Insured's Current Mailing Address _____

Primary Insured or Patient's Email _____

Primary Insured or Patient's Phone Number _____

2 Other Health Insurance

Is the patient covered under other health insurance? Including Medicare A or B? Yes No
(If YES, please complete the following section)

Name and Address of Other Insurance Company _____

Name of Primary Insured *(First name, last name)* _____

Primary Insured's Date of Birth *(MM/DD/YYYY)* _____

Policy or Identification Number of Other Coverage _____

Policy Effective Date *(MM/DD/YYYY)* _____ Policy Termination Date *(MM/DD/YYYY)* _____

3 Trip Information *(Please indicate the dates of your travel/trip)*

Trip Start Date *(MM/DD/YYYY)* _____ Trip End Date *(MM/DD/YYYY)* _____

4 Diagnosis *(Describe illness, injury or symptoms requiring treatment)*

Was this an auto accident? Yes No

Was patient's treatment due to an accident? Yes No *(If YES, please describe the accident below including the date it occurred)*

Was this a work-related accident? Yes No *(If the accident was caused by someone else, attach a statement describing the accident)*

Description of Diagnosis/Injury _____

Have you been treated for the same condition within the last 24 months? Yes No *(If YES, indicate the date treatment began and the date you were last treated)*

Began Treatment *(MM/DD/YYYY)* _____ Last Treatment *(MM/DD/YYYY)* _____

5 Charges (List each type of service or provider in the sections below and attach itemized bills for all services)

Name, Street, City & Country of Provider Making Charge _____

Diagnosis (i.e. back pain, etc.) _____

Service or Prescription (i.e. X-ray, Tylenol, etc.) _____

Dates of Service (MM/DD/YYYY) _____ Charges (Please indicate currency) _____

Name, Street, City & Country of Provider Making Charge _____

Diagnosis (i.e. back pain, etc.) _____

Service or Prescription (i.e. X-ray, Tylenol, etc.) _____

Dates of Service (MM/DD/YYYY) _____ Charges (Please indicate currency) _____

Name, Street, City & Country of Provider Making Charge _____

Diagnosis (i.e. back pain, etc.) _____

Service or Prescription (i.e. X-ray, Tylenol, etc.) _____

Dates of Service (MM/DD/YYYY) _____ Charges (Please indicate currency) _____

6 Claim Payment Reimbursement

Make Payment to the Provider (If payment is to be paid, ensure the bank information is on the provider invoice)

Make Payment to Primary Insured (Payable in U.S. dollars by check and mailed to the address indicated above)

7 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 Blue Cross Blue Shield Global SolutionsSM 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. If a person is under 18 years of age, this form must be signed by their parent/guardian/school administrator in the space provided below.

Signature of Primary Insured Member or Patient _____ Date _____

General Fraud Warning

Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

Instructions for Filing a Claim

The following steps will help you in filing claims. **Please note, incomplete form submissions will delay the processing of your claim(s).**

For Parts 1–5 of the claim form:

- Please submit a **separate claim** form for each patient.
- Please be as descriptive as possible.
- Submitted bills must be **itemized**—canceled check, cash register receipts and non-itemized “balance due” statements **cannot** be processed.
- An itemized bill is a full description of all actual charges and each itemized bill must include:
 - Name and address of provider (doctor, hospital, laboratory, ambulance service, etc.), banking information of provider, name of patient, date(s) of service, amount charged for each service described, diagnosis or reason for treatment.
 - Submitted bills for prescriptions should include the name of the drug, the quantity dispensed and the dosage.

To accurately complete Part 6 of the claim form:

- Payments are made to the **Primary Insured** on the plan. Payments cannot be made directly to a dependent or to a third party (other than the Service Provider).
- For funds sent to an international bank account, the bank IBAN number is mandatory.
- **If paying an international provider, invoice must include bank information.**

Send completed claim forms, written inquiries and address changes to:

Blue Cross Blue Shield Global Solutions
Claims Department
PO Box 1748
Southeastern, PA 19399-1748

Claims Submission Fax: +1 610 482 9623

Claims Submission Email: claims@bcbsglobalsolutions.com

24/7/365 Member Services | Outside the U.S.: +1 610 254 5850 | Inside the U.S.: 855 481 6647