

# International Claim Form



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

Send completed form and documentation to: Service Center or [claims@bcbsglobalcore.com](mailto:claims@bcbsglobalcore.com)  
or online at [www.bcbsglobalcore.com](http://www.bcbsglobalcore.com)  
P.O. Box 2048  
Southeastern, PA 19399

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

**1. Patient Information — 1A. Member ID** *Include all letters and numbers as shown on your Blue Cross Blue Shield identification card*

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<b>1B. Patient's name</b> (First, middle initial, last)	<b>1C. Patient's date of birth</b> MM/DD/YYYY	<b>1D. Patient's sex</b> Male Female
<b>1E. Name of subscriber</b> (First, middle initial, last)	<b>1F. Subscriber's date of birth</b> MM/DD/YYYY	<b>1G. Patient's relationship to subscriber</b> Self Spouse Child
<b>1H. Subscriber's current mailing address</b> (Street, city, state, and country or ZIP code)		<b>1I. Patient's e-mail address</b>

**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**

<b>2B. Type of policy</b> Family Individual	<b>2C. Effective date</b> MM/DD/YYYY	<b>2D. Termination date</b> MM/DD/YYYY	<b>2E. Policy or identification number of other coverage</b>	
<b>2F. Type of coverage</b> Hospital: Yes No Medical: Yes No Mental illness: Yes No		<b>2G. Name of subscriber</b>		<b>2H. Date of birth</b> MM/DD/YYYY
<b>2I. Employer of subscriber</b>			<b>2J. Employment status</b> Active employee Retired employee	
<b>2K. If patient is covered under Medicare, complete the following:</b>				
Medicare Part A: Yes No		Medicare Part B: Yes No		Effective date _____
Effective date _____		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
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.....	.....	.....	.....	.....
.....	.....	.....	.....	.....

**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** \_\_\_\_\_

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## 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.

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## 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.

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## 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.

# Notice of Nondiscrimination and Availability of Language Assistance Services

(UPDATED 8/5/19)

CareFirst BlueCross BlueShield, CareFirst BlueChoice, Inc., CareFirst Diversified Benefits and all of their corporate affiliates (CareFirst) comply with applicable federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability or sex. CareFirst does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

CareFirst:

- Provides free aid and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

**If you need these services, please call 855-258-6518.**

If you believe CareFirst 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 CareFirst Civil Rights Coordinator by mail, fax or email. If you need help filing a grievance, our CareFirst Civil Rights Coordinator is available to help you.

**To file a grievance regarding a violation of federal civil rights, please contact the Civil Rights Coordinator as indicated below. Please do not send payments, claims issues, or other documentation to this office.**

## Civil Rights Coordinator, Corporate Office of Civil Rights

Mailing Address	P.O. Box 8894 Baltimore, Maryland 21224
Email Address	<a href="mailto:civilrightscoordinator@carefirst.com">civilrightscoordinator@carefirst.com</a>
Telephone Number	410-528-7820
Fax Number	410-505-2011

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  
800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

## Foreign Language Assistance

*Attention (English): This notice contains information about your insurance coverage. It may contain key dates and you may need to take action by certain deadlines. You have the right to get this information and assistance in your language at no cost. Members should call the phone number on the back of their member identification card. All others may call 855-258-6518 and wait through the dialogue until prompted to push 0. When an agent answers, state the language you need and you will be connected to an interpreter.*

*አማርኛ (Amharic) ማሳሰቢያ፡- ይህ ማስታወቂያ ስለ መድን ሽፋንዎ መረጃ ይዟል። ከተወሰኑ ቀን-ገደቦች በፊት ሊፈጽሟቸው የሚገቡ ነገሮች ሊኖሩ ስለሚችሉ እነዚህን ወሳኝ ቀናት ሊይዝ ይችላሉ። ይኸን መረጃ የማግኘት እና ያለምንም ክፍያ በቋንቋዎ አገዛ የማግኘት መብት አለዎት። አባል ከሆኑ ከመታወቂያ ካርድዎ በስተጀርባ ላይ ወደተጠቀሰው የስልክ ቁጥር መደወል ይችላሉ። አባል ካልሆኑ ደግሞ ወደ ስልክ ቁጥር 855-258-6518 ደውለው 0ን እንዲጫኑ እስኪነገርዎ ድረስ ንግግሩን መጠበቅ አለብዎ። አንድ ወኪል መልስ ሲሰጥዎ፣ የሚፈልጉትን ቋንቋ ያሳውቁ፣ ከዚያም ከተርጓሚ ጋር ይገናኛሉ።*

*Èdè Yorùbá (Yoruba) Ìtètíléko: Àkíyèsí yìí ní iwífún nípa isẹ adójútòfò rẹ. Ó le ní àwọn déèti pàtó o sì le ní láti gbé igbésé ní àwọn ojò gbèdèké kan. O ni ètò láti gba iwífún yìí àti irànlówó ní èdè rẹ lófèé. Àwọn omọ-egbé gbòdò pe nóm̀bà fòdùn tò wà lèyìn kààdì idánimò wọn. Àwọn mírán le pe 855-258-6518 kí o sì dúró nípasè ijíròrò tí tí a ó fí sọ fún ọ láti tẹ 0. Nígbatí așojú kan bá dáhùn, sọ èdè tí o fẹ a ó sì sọ ọ pò mò ògbufò kan.*

*Tiếng Việt (Vietnamese) Chú ý: Thông báo này chứa thông tin về phạm vi bảo hiểm của quý vị. Thông báo có thể chứa những ngày quan trọng và quý vị cần hành động trước một số thời hạn nhất định. Quý vị có quyền nhận được thông tin này và hỗ trợ bằng ngôn ngữ của quý vị hoàn toàn miễn phí. Các thành viên nên gọi số điện thoại ở mặt sau của thẻ nhận dạng. Tất cả những người khác có thể gọi số 855-258-6518 và chờ hết cuộc đối thoại cho đến khi được nhắc nhấn phím 0. Khi một tổng đài viên trả lời, hãy nêu rõ ngôn ngữ quý vị cần và quý vị sẽ được kết nối với một thông dịch viên.*

*Tagalog (Tagalog) Atensyon: Ang abisong ito ay naglalaman ng impormasyon tungkol sa nasasaklawan ng iyong insurance. Maaari itong maglaman ng mga pinakamahalagang petsa at maaaring kailangan mong gumawa ng aksyon ayon sa ilang deadline. May karapatan ka na makuha ang impormasyong ito at tulong sa iyong sariling wika nang walang gastos. Dapat tawagan ng mga Miyembro ang numero ng telepono na nasa likuran ng kanilang identification card. Ang lahat ng iba ay maaaring tumawag sa 855-258-6518 at maghintay hanggang sa dulo ng diyalogo hanggang sa diktahan na pindutin ang 0. Kapag sumagot ang ahente, sabihin ang wika na kailangan mo at ikokonekta ka sa isang interpreter.*

*Español (Spanish) Atención: Este aviso contiene información sobre su cobertura de seguro. Es posible que incluya fechas clave y que usted tenga que realizar alguna acción antes de ciertas fechas límite. Usted tiene derecho a obtener esta información y asistencia en su idioma sin ningún costo. Los asegurados deben llamar al número de teléfono que se encuentra al reverso de su tarjeta de identificación. Todos los demás pueden llamar al 855-258-6518 y esperar la grabación hasta que se les indique que deben presionar 0. Cuando un agente de seguros responda, indique el idioma que necesita y se le comunicará con un intérprete.*

*Русский (Russian) Внимание! Настоящее уведомление содержит информацию о вашем страховом обеспечении. В нем могут указываться важные даты, и от вас может потребоваться выполнить некоторые действия до определенного срока. Вы имеете право бесплатно получить настоящие сведения и сопутствующую помощь на удобном вам языке. Участникам следует обращаться по номеру телефона, указанному на тыльной стороне идентификационной карты. Все прочие абоненты могут звонить по номеру 855-258-6518 и ожидать, пока в голосовом меню не будет предложено нажать цифру «0». При ответе агента укажите желаемый язык общения, и вас свяжут с переводчиком.*

हिन्दी (Hindi) ध्यान दें: इस सूचना में आपकी बीमा कवरेज के बारे में जानकारी दी गई है। हो सकता है कि इसमें मुख्य तिथियों का उल्लेख हो और आपके लिए किसी नियत समय-सीमा के भीतर काम करना ज़रूरी हो। आपको यह जानकारी और संबंधित सहायता अपनी भाषा में निःशुल्क पाने का अधिकार है। सदस्यों को अपने पहचान पत्र के पीछे दिए गए फ़ोन नंबर पर कॉल करना चाहिए। अन्य सभी लोग 855-258-6518 पर कॉल कर सकते हैं और जब तक 0 दबाने के लिए न कहा जाए, तब तक संवाद की प्रतीक्षा करें। जब कोई एजेंट उत्तर दे तो उसे अपनी भाषा बताएँ और आपको व्याख्याकार से कनेक्ट कर दिया जाएगा।

Bàsòò-wùdù (Bassa) Tò Dùù Cáò! Bǎ nìà kè bá nyò bě kè m̄ gbo kpá bó nì fùà-fúá-tiǐn nyεε jè dyí. Bǎ nìà kè bédé wé jéé bě b́é m̄ kè dε wa ḿ m̄ kè nyuεε nyu hwè b́é wé b́éa kè zi. Ǿ m̀ò nì kpé b́é m̄ kè bǎ nìà kè kè gbo-kpá-kpá m̄ ḿεε dyé dé nì bídí-wùdù mú b́é m̄ kè se wídí d̀ò péè. Kpooò nyò b́é m̄ dá fúùn-nòbà nìà dé waa I.D. káàò d́éin nyε. Nyò t̀òò séin m̄ dá nòbà nìà kè: 855-258-6518, kè m̄ m̄ f̀ò tee b́é wa ḱε m̄ gbo ćé b́é m̄ kè nòbà m̀òà 0 ḱε dyi pàd̀àn hwè. Ǿ j̀ú kè nyò d̀ò dyi m̄ g̀ǎ j̀ùin, po wuqu m̄ ḿ poε dyie, kè nyò d̀ò mu bó nìin b́é Ǿ kè nì wuquò mú zà.

বাংলা (Bengali) লক্ষ্য করুন: এই নোটিশে আপনার বিমা কভারেজ সম্পর্কে তথ্য রয়েছে। এর মধ্যে গুরুত্বপূর্ণ তারিখ থাকতে পারে এবং নির্দিষ্ট তারিখের মধ্যে আপনাকে পদক্ষেপ নিতে হতে পারে। বিনা খরচে নিজের ভাষায় এই তথ্য পাওয়ার এবং সহায়তা পাওয়ার অধিকার আপনার আছে। সদস্যদেরকে তাদের পরিচয়পত্রের পিছনে থাকা নম্বরে কল করতে হবে। অন্যেরা 855-258-6518 নম্বরে কল করে 0 টিপতে না বলা পর্যন্ত অপেক্ষা করতে পারেন। যখন কোনো এজেন্ট উত্তর দেবেন তখন আপনার নিজের ভাষার নাম বলুন এবং আপনাকে দোভাষীর সঙ্গে সংযুক্ত করা হবে।

اردو (Urdu) توجہ: یہ نوٹس آپ کے انشورینس کوریج سے متعلق معلومات پر مشتمل ہے۔ اس میں کلیدی تاریخیں ہو سکتی ہیں اور ممکن ہے کہ آپ کو مخصوص آخری تاریخوں تک کارروائی کرنے کی ضرورت پڑے۔ آپ کے پاس یہ معلومات حاصل کرنے اور بغیر خرچہ کیے اپنی زبان میں مدد حاصل کرنے کا حق ہے۔ ممبران کو اپنے شناختی کارڈ کی پشت پر موجود فون نمبر پر کال کرنی چاہیے۔ سبھی دیگر لوگ 855-258-6518 پر کال کر سکتے ہیں اور 0 دبانے کو کہے جانے تک انتظار کریں۔ ایجنٹ کے جواب دینے پر اپنی مطلوبہ زبان بتائیں اور مترجم سے مربوط ہو جائیں گے۔

فارسی (Farsi) توجہ: این اعلامیہ حاوی اطلاعاتی درباره پوشش بیمه شما است. ممکن است حاوی تاریخ های مهمی باشد و لازم است تا تاریخ مقرر شده خاصی اقدام کنید. شما از این حق برخوردار هستید تا این اطلاعات و راهنمایی را به صورت رایگان به زبان خودتان دریافت کنید. اعضا باید با شماره درج شده در پشت کارت شناسایی شان تماس بگیرند. سایر افراد می توانند با شماره 855-258-6518 تماس بگیرند و منتظر بمانند تا از آنها خواسته شود عدد 0 را فشار دهند. بعد از پاسخگویی توسط یکی از اپراتورها، زبان مورد نیاز را تنظیم کنید تا به مترجم مربوطه وصل شوید.

اللغة العربية (Arabic) تنبيه: يحتوي هذا الإخطار على معلومات بشأن تغطيتك التأمينية، وقد يحتوي على تواريخ مهمة، وقد تحتاج إلى اتخاذ إجراءات بحلول مواعيد نهائية محددة. يحق لك الحصول على هذه المساعدة والمعلومات بلغتك بدون تحمل أي تكلفة. ينبغي على الأعضاء الاتصال على رقم الهاتف المذكور في ظهر بطاقة تعريف الهوية الخاصة بهم. يمكن للأخريين الاتصال على الرقم 855-258-6518 والانتظار خلال المحادثة حتى يطلب منهم الضغط على رقم 0. عند إجابة أحد الوكلاء، اذكر اللغة التي تحتاج إلى التواصل بها وسيتم توصيلك بأحد المترجمين الفوريين.

中文繁体 (Traditional Chinese) 注意：本聲明包含關於您的保險給付相關資訊。本聲明可能包含重要日期及您在特定期限之前需要採取的行動。您有權利免費獲得這份資訊，以及透過您的母語提供的協助服務。會員請撥打印在身分識別卡背面的電話號碼。其他所有人士可撥打電話 855-258-6518，並等候直到對話提示按下按鍵 0。當接線生回答時，請說出您需要使用的語言，這樣您就能與口譯人員連線。

*Igbo (Igbo)* Nrubama: Okwa a nwere ozi gbasara mkpuchi nchekwa onwe gi. O nwere ike inwe ubochi ndi di mkpa, i nwere ike ime ihe tupu ufodu ubochi njedebe. I nwere ikike inweta ozi na enyemaka a n'asusu gi na akwughi ugwo o bula. Ndi otu kwesiri ikpo akara ekwentu di n'azu nke kaadi njirimara ha. Ndi ozo niile nwere ike ikpo 855-258-6518 wee chere ububo ahu ruo mgbe amanyere ipi 0. Mgbe onye nnochite anya zara, kwuo asusu i choro, a ga-ejiko gi na onye okowa okwu.

*Deutsch (German)* Achtung: Diese Mitteilung enthält Informationen über Ihren Versicherungsschutz. Sie kann wichtige Termine beinhalten, und Sie müssen gegebenenfalls innerhalb bestimmter Fristen reagieren. Sie haben das Recht, diese Informationen und weitere Unterstützung kostenlos in Ihrer Sprache zu erhalten. Als Mitglied verwenden Sie bitte die auf der Rückseite Ihrer Karte angegebene Telefonnummer. Alle anderen Personen rufen bitte die Nummer 855-258-6518 an und warten auf die Aufforderung, die Taste 0 zu drücken. Geben Sie dem Mitarbeiter die gewünschte Sprache an, damit er Sie mit einem Dolmetscher verbinden kann.

*Français (French)* Attention: cet avis contient des informations sur votre couverture d'assurance. Des dates importantes peuvent y figurer et il se peut que vous deviez entreprendre des démarches avant certaines échéances. Vous avez le droit d'obtenir gratuitement ces informations et de l'aide dans votre langue. Les membres doivent appeler le numéro de téléphone figurant à l'arrière de leur carte d'identification. Tous les autres peuvent appeler le 855-258-6518 et, après avoir écouté le message, appuyer sur le 0 lorsqu'ils seront invités à le faire. Lorsqu'un(e) employé(e) répondra, indiquez la langue que vous souhaitez et vous serez mis(e) en relation avec un interprète.

*한국어(Korean)* 주의: 이 통지서에는 보험 커버리지에 대한 정보가 포함되어 있습니다. 주요 날짜 및 조치를 취해야 하는 특정 기한이 포함될 수 있습니다. 귀하에게는 사용 언어로 해당 정보와 지원을 받을 권리가 있습니다. 회원이신 경우 ID 카드의 뒷면에 있는 전화번호로 연락해 주십시오. 회원이 아닌 경우 855-258-6518 번으로 전화하여 0을 누르라는 메시지가 들릴 때까지 기다리십시오. 연결된 상담원에게 필요한 언어를 말씀하시면 통역 서비스에 연결해 드립니다.

*Diné Bizaad (Navajo)* Ge': Díí bee íł hane'ígíí bii' dahóló bee éédahózin béeso ách'ááh naanil ník'ist'í'ígíí bá. Bii' dahólóq doo íiyisíí yoolkáálígíí dóo t'áadoo le'é ádadoolyíí'ígíí da yókeedgo t'áa doo bee e'e'aa'ahí ájiil'ííh. Bee ná ahóót'í' díí bee íł hane' dóo níká'ádoowól t'áa nínizaad bee t'áa jii'k'é. Atah danilínígíí béesh bee hane'é bee wólta'ígíí nit'izgo bee nee hódolzinígíí bikéédéé' bikáá' bich'í' hodoonihjí'. Aadóo náána'á' éí kójjí' dahóoolnih 855-258-6518 dóo yíi dii'łts'ííł yałtí'ígíí t'áa níléj'í' áádóo éí bikéé'dóo naasbaqas bíł adidiilchíł. Áká'ánidaalwó'ígíí neidiitáágo, saad bee yáníłt'í'ígíí yíi diikił dóo ata' halne'é lá níká'ádoowól.