



## Federal Employee Program RETAIL PRESCRIPTION DRUG OVERSEAS CLAIM FORM

CUT0154-1S F 09/19

Federal Employee Program®

## INSTRUCTIONS

- This form is to provide direct reimbursement for prescriptions that were purchased outside the United States.
- Pharmacy receipts and Enrollee/Patient signature are required.
- Please use a separate claim form for each patient.
- Do not staple receipts or attachments to this form.
- Timely filing for overseas pharmacy claims is limited to one year from the prescription fill date.

ENROLLEE'S OR POLICY HOLDER'S INFORMA	TION REQUIRED:
	IDENTIFICATION NUMBER
Insured's Name:	R
Street	EMAIL ADDRESS
Address:	LIMAL ADDITEOU
	Mail Completed Form to:
01.4	Service Benefit Plan Retail Pharmacy Program
City: State	Zip: Retail Pharmacy Program P.O. Box 52057
Country:	Phoenix, AZ 85072-2057
	and that I am claiming benefits only for the charges for the patient named
	r of service who participated in any way in the patient's care, to release any
	adjudicate this claim. I also authorize release of all information contained on
assignable and that any assignment of these benefit	ator. I agree that any benefits payable hereunder for prescription drugs are not
PATIENT INFORMATION REQUIRED:	its shall be volu.
LAST	FIRST
Patient	Patient's Relationship to insured:
Name:	
Data of	Self Spouse Dependent
Date of Birth:	Male: Female:
FOREIGN COUNTRY INFORMATION:	maio. — I officio. —
Country Where Drugs Purchased:	Country Currency Type
PRESCRIPTION CLAIM INFORMATION: (one med	dication per line)
MONTH DAY YEAR	
Date Purchased LLL LLL LLL Name of Medication	Quantity (how many) Days Supply:  Prescription Cost
U.S. Drug Equivalent Name	Prescription Cost
Form of Medication (capsules, cream, etc.)	Strength (250 mg., etc.):
Prescriber Name	Prescriber Address
MONTH DAY YEAR	
Date Purchased	Quantity (how many) Days Supply:
Name of Medication	Prescription Cost
U.S. Drug Equivalent Name	1 103011ption 003t
Form of Medication (capsules, cream, etc.)	Strength (250 mg., etc.):
Prescriber Name	Prescriber Address
MONTH DAY YEAR	
Date Purchased	Quantity (how many) Days Supply:
Name of Medication	Prescription Cost
U.S. Drug Equivalent Name	
Form of Medication (capsules, cream, etc.)	Strength (250 mg., etc.):
Prescriber Name:	Prescriber Address:
Enrollee/Patient Signature:	Date:

## **General Information**

This Retail Prescription Drug Overseas Claim Form is to be used only to submit a claim for benefits for prescription drugs purchased outside of the United States and Puerto Rico. Please complete a separate claim form for each patient. Timely filing for overseas pharmacy claims is limited to one year from the prescription fill date.

The Retail Prescription Drug Overseas Claim Form must be completed in full and accompanied by the prescription drug receipts/bills. **ENROLLEE/PATIENT SIGNATURE REQUIRED.** 

Please be sure to keep photocopies of the claim form and all bills and supporting documentation for your personal records.

Any person who knowingly and with intent to defraud any insurance company or other person files a claim for reimbursement containing any materially false information or conceals for the purpose of misleading commits a fraudulent insurance act, which is a crime and subject to criminal and civil penalties.

**Prescription Claim Information** – Please list the prescriptions included on this claim. Although we require prescription drug receipts, your listing will enable us to process the claim more quickly and accurately.

- Date Purchased The date you paid for the prescription.
- Quantity The number of tablets, capsules, or the liquid measure of the prescription.
- Days Supply The number of days for which the prescription was written.
- Name of Medication The name of the medication as indicated on the prescription drug receipt.
- U.S. Drug Equivalent Name The name of the prescription drug in English.
- Form of Medication Such as a cream, tablets, capsules, liquid, etc.
- Strength This is the strength of medication per dose, such as 50 mg for tables or .05 ml for liquids.
- Prescription Cost Please indicate the cost you paid in foreign currency.

THIS SIGNED AND COMPLETED CLAIM FORM, TOGETHER WITH YOUR PRESCRIPTION DRUG RECEIPTS/BILLS SHOULD BE SUMITTED TO THE ADDRESS ON THE FRONT OF THE FORM, OR YOU CAN FAX TO: 001-480-614-7674

DIRECT DEPOSIT TO YOUR BANK ACCOUNT IS CURRENTLY NOT AVAILABLE FOR OVERSEAS PHARMACY CLAIMS PAYMENT. PAYMENT WILL BE MADE BY CHECK IN U.S. CURRENCY.

PLEASE USE THE FEDERAL EMPLOYEE PROGRAM OVERSEAS MEDICAL CLAIM FORM FOR ALL OTHER MEDICAL EXPENSES INCURRED OUTSIDE THE US AND PUERTO RICO.

YOU MAY BE ASKED TO PROVIDE ADDITIONAL DOCUMENTATION SUCH AS PROOF OF PAYMENT, CREDIT CARD RECEIPTS, BANK STATEMENTS, COPIES OF PRESCRIBER PRESCRIPTIONS, MEDICAL CLAIMS, AND PROOF THAT MEDICATION HAS BEEN PHYSICALLY RECEIVED.

ADDITIONAL CLAIM FORMS OR INFORMATION ARE AVAILABLE ON OUR WEB SITE, www.fepblue.org. OR BY CALLING 1-888-999-9862