BlueCross BlueShield
Blue Crescent℠

Federal Employee Program
OVERSEAS MEDICAL CLAIM FORM

Please see the instructions on the reverse side of this form before completing
PLEASE TYPE OR PRINT.

A. ENROLLMENT CODE 1 __ __ **IDENTIFICATION NUMBER** R __ __ __ __ __ __ __ __

1. PATIENT INFORMATION

B. PATIENT'S NAME (First, Middle Initial, Last)

C. PATIENT'S DATE OF BIRTH

D. PATIENT'S SEX ☐ Male ☐ Female

E. NAME OF SUBSCRIBER OR POLICY HOLDER (First, Middle Initial, Last)

F. SUBSCRIBER'S DATE OF BIRTH Month | Day | Year

G. PATIENT'S RELATIONSHIP TO SUBSCRIBER ☐ Self ☐ Spouse ☐ Dependent

If the patient's last name is different from the subscriber's, please attach a statement explaining the relationship

H. SUBSCRIBER'S CURRENT MAILING ADDRESS (Street, City, State, and Country or ZIP Code)

2. OTHER HEALTH INSURANCE

Is the patient covered under other Health Insurance?
If yes, complete items A through J below. ( ) Yes ( ) No

A. Name and Address of Insuring Company

B. Type of Policy
( ) Family
( ) Individual

C. Effective Date
Month | Day | Year

D. Termination Date
Month | Day | Year

E. Policy or Identification Number of Other Coverage

F. Type of Coverage
Medical ( ) Yes ( ) No
Dental ( ) Yes ( )

G. Name of Policy Holder

H. Date of Birth

I. Employer of Policy Holder

J. Employment Status
( ) Active Employee
( ) Retired Employee

3. MEDICARE

Complete this section regardless of the patient's age. **If you are covered by a Medicare HMO/Prepaid Plan, please leave Sections A and B blank**

A. Medicare Part A ( ) Yes ( ) No
Effective Date

B. Medicare Part B ( ) Yes ( ) No
Effective Date

C. Medicare HMO/ Prepaid Plan
( ) Yes ( ) No
Effective Date

D. Medicare ID #

E. Is the Subscriber an active Federal Employee? ( ) Yes ( ) No
Is the patient an active Federal Employee? ( ) Yes ( ) No

F. End Stage Renal patients, please indicate the beginning date of renal treatment.
Month | Day | Year

4. DIAGNOSIS

A. Describe illness, injury, or symptoms requiring treatment, e.g. cough, sore throat.

B. Was patient's treatment due to a work-related accident or condition?
( ) Yes ( ) No

C. Complete for care related to accidental injuries.
DATE OF ACCIDENT________ TIME OF ACCIDENT ________
LOCATION ( ) at home ( ) auto ( ) other ________
If the accident was caused by someone else, attach a statement describing the accident.

5. CHARGES

Please list below those charges that you are claiming for benefits. Use a separate line for each type of service or provider and attach itemized bills for all services claimed.

A. TYPE OF PROVIDER	B. NAME OF PROVIDER MAKING CHARGE	C. DESCRIPTION OF SERVICE	D. DATES OF SERVICE OR PURCHASE	E. CHARGE

6. MEMBER PAYMENT INFORMATION

Select one from each of the following payment options:
Payment Method: ☐ Check ☐ Bank Wire
Currency: ☐ U.S. Dollars ☐ Currency on itemized bill

6A. BANK WIRE INFORMATION

Please complete if you selected Bank Wire Payment:

Name on Bank Account ________

Bank Name: ________

Bank Physical Address: ________

ABA# __ __ __ __ __ __ __ __ __

(IBAN)# ________

(BIC/SWIFT) ________

International Bank Account/ Bank Identifier Code ________

6B. AUTHORIZATION FOR ASSIGNMENT OF BENEFITS

I, the undersigned, authorize and request CareFirst BlueCross BlueShield to make payment for benefits due herein to:

____
Name of Provider

________ ________
Signature of Subscriber or Spouse Date

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, which participated in any way in the patient's care, to release to CareFirst BlueCross BlueShield, any medical information which they deem necessary to adjudicate this claim.

____
Date

________ ________
Signature of Subscriber or Patient Home Phone Number

FEDERAL EMPLOYEE PROGRAM OVERSEAS MEDICAL CLAIM FORM

PLEASE USE THE RETAIL PRESCRIPTION DRUG OVERSEAS CLAIM FORM FOR ALL PRESCRIPTION DRUGS PURCHASED AT PHARMACIES OUTSIDE OF THE U.S. AND PUERTO RICO.

GENERAL INFORMATION
This Overseas Medical Claim Form is to be used to submit a claim for benefits for covered services received outside the United States and Puerto Rico. Please complete a separate claim form for each patient and remember to file all claims by December 31 of the calendar year after the one in which the covered care or service was provided.
The Overseas Medical Claim Form must be completed in full, and accompanied by fully itemized bills.

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

OVERSEAS MEDICAL CLAIM FORM INSTRUCTIONS

Please complete all items on the claim form. If the information requested does not apply to the patient, indicate N/A (Not Applicable). Special care should be taken when completing the following items:

2. **OTHER HEALTH INSURANCE** – If the patient holds other insurance coverage, please complete items A through J 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 Policy Holder 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.

3. **MEDICARE** – Medicare benefits are often limited for care provided outside the United States and its territories. Please refer to your Medicare handbook. However, please complete item 3 regardless of the patient's age.

4. **DIAGNOSIS** – Describe illness, injury, or symptoms requiring treatment, e.g. cough, sore throat.

5. **CHARGES** – Please list here the bills that are being included on this claim. Although itemized bills must also be submitted, your listing will enable us to process the claim more quickly and accurately. If additional space is needed for listing charges, please use a separate sheet of paper to list the following information.

   A. TYPE OF PROVIDER – for example: hospital, nurse, physician, dentist, physical therapist, etc.

   B. NAME 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 types of service.

   C. DESCRIPTION OF SERVICE – for example: hospital admission, office visit, dental care, x-ray, laboratory test, surgery, etc.

   D. DATE OF SERVICE OR PURCHASE – inclusive dates may be indicated for bills containing multiple dates of service.

   E. CHARGE – Bills must be itemized to show a separate charge for each service. If the bill has already been paid, please indicate the date it was paid.

6. **MEMBER PAYMENT INFORMATION** – **Make payment to subscriber, designation of currency and payment method** – Indicate whether you want to be paid in the currency reflected on the bill(s) or in U.S. dollars and if you want to receive payment via check or bank wire. 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 will typically charge a flat fee or percentage-based 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.

6A. BANK WIRE INFORMATION – You must include the following information on this form: your full name (initials are not acceptable) and your physical address (payments cannot be sent to a P.O. box). For wire payments, subscriber's name as it appears on the bank account, the bank's name and physical address (payments cannot be wired to a P.O. box), account number, ABA number. Please provide a copy of a voided check or deposit slip so that the bank information can be validated. Additionally, for wire payments to European Union countries, you must provide the International Bank Account Number (IBAN) and Bank Identifier Code (BIC/SWIFT). For checks to be sent by express mail, you must provide a current telephone number.

6B. AUTHORIZATION FOR ASSIGNMENT OF BENEFITS – Complete this item if you prefer benefits be paid directly to the provider of service.

7. **SIGNATURE** – The Overseas Medical Claim Form must be signed and dated by the Policy Holder, spouse, or the patient.

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

THIS COMPLETED CLAIM FORM, TOGETHER WITH ITEMIZED BILLS AND SUPPORTING DOCUMENTATION, SHOULD BE SUBMITTED TO:

MAIL ADMINISTRATOR, P.O. BOX 14113 Lexington, Ky 40512-4113
YOU CAN ALSO FAX YOUR CLAIMS TO EITHER 1-888-650-6525 OR 410-781-7637
DEPENDING ON THE LOCATION THAT YOU FAX FROM, YOU MAY NOT NEED TO ADD THE 1 IN FRONT OF THE 888 FAX NUMBER.

PLEASE USE THE RETAIL PRESCRIPTION DRUG OVERSEAS CLAIM FORM FOR ALL PRESCRIPTION DRUGS PURCHASED AT PHARMACIES OUTSIDE THE US AND PUERTO RICO.

ADDITIONAL CLAIM FORMS and FAX DIALING INSTRUCTIONS AVAILABLE ON www.fepblue.org. OR BY CALLING 1-888-999-9862