BlueCross® BlueShield® Blue Crescent℠

Clear Form

Federal Employee Program
OVERSEAS MEDICAL CLAIM FORM

ENROLLMENT CODE: 1 | IDENTIFICATION NUMBER: R

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

1. PATIENT INFORMATION

1A. PATIENT'S NAME (First Name, Middle Initial, Last Name)

1B. PATIENT'S DATE OF BIRTH (Month/Day/Year)

1C. PATIENT'S GENDER ☐ Male ☐ Female

1D. PATIENT'S RELATIONSHIP TO CONTRACT HOLDER ☐ Self ☐ Spouse ☐ Dependent

1E. NAME OF CONTRACT HOLDER (First Name, Middle Initial, Last Name)

1F. CONTRACT HOLDER'S DATE OF BIRTH (Month/Day/Year)

1G. CONTRACT HOLDER'S CURRENT MAILING ADDRESS (Street, City, State and Country or ZIP)

1H. EMAIL ADDRESS

2. OTHER HEALTH INSURANCE

2A. IS PATIENT COVERED UNDER OTHER HEALTH INSURANCE? If yes, complete items A through K below. Yes ☐ No ☐

2B. NAME AND ADDRESS OF INSURING COMPANY

2C. POLICY OR IDENTIFICATION NUMBER OF OTHER COVERAGE

2D. NAME OF CONTRACT HOLDER (First Name, Middle Initial, Last Name)

2E. TYPE OF POLICY Family ☐ Individual ☐

2F. TYPE OF COVERAGE Medical ☐ Yes ☐ No; Dental ☐ Yes ☐ No

2I. CONTRACT HOLDER DATE OF BIRTH (Month/Day/Year)

2J. EMPLOYER OF CONTRACT HOLDER

2G. EFFECTIVE DATE (Month/Day/Year)

2H. TERMINATION DATE (Month/Day/Year)

2K. EMPLOYMENT STATUS ☐ Active Employee ☐ Retired Employee

3. DIAGNOSIS

3A. DESCRIBE REASON FOR VISIT:
Routine care, illness, injury, or symptoms requiring treatment (e.g., cough, sore throat).

3B. WAS TREATMENT DUE TO WORK RELATED ACCIDENT OR CONDITION? ☐ Yes ☐ No

3C. COMPLETE FOR CARE RELATED TO ACCIDENTAL INJURIES Date of Accident _____ Time of Accident _____ ☐ AM ☐ PM
Location ☐ Home ☐ Auto ☐ Other If Other is seleceted, please explain _____

4. CHARGES

4. CHARGES Please list below: Begin and End date for charges that are being claimed

BEGIN DATE _____ END DATE _____ TOTAL CHARGES _____ NUMBER OF ITEMIZED BILLS _____

5. REIMBURSEMENT INFORMATION

5A. CONTRACT HOLDER REIMBURSEMENT INFORMATION
Select type of reimbursement:
(Skip to 5C to authorize reimbursement to be issued to provider)
Note: Omission or errors in payment information will result in receipt of a check in US Dollars

☐ US Dollars Check ☐ US Dollars Electronic Funds Transfer ☐ Currency on Bills Electronic Funds Transfer

Clear Section

5B. COMPLETE FOR BANK WIRE

Name on Bank Account (Contract Holder) _____ Bank Name _____

Complete Bank Address (Street) _____

City _____ State _____ Zip Code _____ Country _____

Routing Number (ABA/SWIFT)

Account Number (Local Bank/IBAN)

5C. AUTHORIZATION FOR ASSIGNMENT OF BENEFITS (Benefits can only be assigned to one provider for each claim. Do not complete this section if requesting a bank wire) I, the undersigned, authorize and request CareFirst BlueCross Blue Shield to make payment for benefits due herein to:

Provider Name _____

Provider Address (Street) _____

City _____ State _____ Zip Code _____ Country _____

Signature of Contract Holder or Spouse _____ Date _____

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. **Submission acts as signature for e-Claims**

Signature of Contract Holder or Patient _____ Date _____ Daytime Telephone Phone Number (Including Area Code) _____

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 UNITED STATES, PUERTO RICO, AND THE U.S. VIRGIN ISLANDS

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, Puerto Rico, and the U.S. Virgin Islands. 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 and supporting documentation (such as medical records and travel documentation, if applicable). Please be sure to keep photocopies of all bills and supporting 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

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:

OTHER HEALTH INSURANCE – If the patient holds other insurance coverage, please complete items 2A through 2K 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.

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DIAGNOSIS – Describe reason for visit, illness, injury, or symptoms requiring treatment, e.g. cough, sore throat.

CHARGES - Please list here the number of bills that are included on this claim. Please attach itemized bills for all services. Please list the beginning and the end date of service.

A. **Begin Date-** The first date of service for which benefits are being claimed
B. **End Date-** The last date of service for which benefits are being claimed
C. **Total Charges-** The total amount being claimed for all bills attached.
D. **Number of Itemized Bills Attached-** Total number of itemized bills for all services being claimed.

MEMBER REIMBURSEMENT INFORMATION – **Make reimbursement to contract holder 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. **If you choose reimbursement via a bank wire, payment can only be issued to the contract holder's bank account. If you choose check, payment can only be issued in U.S. dollars.** 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. Omission or errors in payment information will result in receipt of a check in US Dollars.

BANK WIRE INFORMATION – You must include the following information on this form: your full name (initials are not acceptable) and your physical address. For wire payments, contract holder'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 and IBAN numbers. 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 (ABA/SWIFT).

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

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

Submission acts as signature for e-Claims

THIS COMPLETED CLAIM FORM, TOGETHER WITH ITEMIZED BILLS AND SUPPORTING DOCUMENTATION, SUCH AS MEDICAL RECORDS AND TRAVEL DOCUMENTATION (IF APPLICABLE), SHOULD BE SUBMITTED TO:

Federal Employee Program (FEP) Overseas Claims, PO Box 260070, PEMBROKE PINES, FL 33026

YOU CAN ALSO FAX YOUR CLAIMS TO 954-308-3957

DEPENDING ON THE LOCATION THAT YOU FAX FROM, YOU MAY NOT NEED TO ADD THE 1 IN FRONT OF THE FAX NUMBER.

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