blue california

International Claim Form

Send completed form to: Blue Shield of California/Blue Shield Life and Health Insurance Company, International Claims, P.O. Box 272550, Chico, CA, 95927-2550, USA

Please see the instructions on the reverse side of this form before completing. Please type or print. This form should only be used if the patient paid out-of-pocket for covered services while out of the country. In all other circumstances, please use the Blue Shield Global Core International Claim Form. To download the Blue Shield Global Core International Claim Form, visit **www.bcbs.com**.

For your protection, California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Section 1 – Member information

1a. Three-character prefix (3 letters or numbers that begin ID number)	ID number (copy this from your Blue Shield ID card)	
1b. Patient's name (first, MI, last)	1c. Patient's date of birth (mo/day/yr)	1d. Patient's gender ☐ Male ☐ Female
1e. Name of subscriber	1f. Subscriber's date of birth (mo/day/yr)	1g. Patient's relationship to subscriber ☐ Self ☐ Spouse ☐ Child ☐ Domestic partner

Subscriber's current mailing address	City	State	ZIP

Section 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 insurance company

2b. Type of contract ☐ Group ☐ Individual	2c. Effective date (mo/day/yr)	2d. Termination date (mo/day/yr)	2e. Policy or ID number of other coverage

2f. Type of coverage Medical ☐ Yes ☐ No	2g. Name of subscriber	2h. Date of birth (mo/day/yr)

Section 3 – Diagnosis

3a. Describe illness, injury, or symptoms requiring treatment	3b. Was patient's condition due to work-related accident or condition? ☐ Yes ☐ No

3c. Complete for care related to accidental injuries
Date of accident _____
Location: ☐ Home while residing outside of United States ☐ Auto ☐ Other _____
Time of accident _____ If accident was caused by someone else, attach a statement describing the accident.

Section 4 – 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 bill for all services claimed.

4a. Name and country of provider making charge	4b. Type of provider	4c. Description of service or supply	4d. Dates of service or purchase	4e. Charges

Section 5 – Signature

I certify the above is complete and accurate to the best of my knowledge 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 Shield of California, Blue Shield of California Life & Health Insurance 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 Blue Shield of California, Blue Shield of California Life & Health Insurance 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 or adjudicate a claim.

Signature of subscriber or patient _____ Date _____

Section 6 – Authorization for assignment of benefits

I, the undersigned, authorize and request Blue Shield of California or Blue Shield of California Life & Health Insurance Company to make payment for benefits due herein to:

Signature of subscriber or patient _____ Date _____

General information

Blue Shield of California/Blue Shield of California Life & Health Insurance Company's International Claim Form is to be used to submit institutional and professional claims for benefits for covered medical services received outside the United States, Puerto Rico, and the U.S. Virgin Islands. For filing instructions for other claim types (e.g., dental, prescription drugs, etc.), contact Blue Shield of California or Blue Shield of California Life & Health Insurance Company.

The International Claim Form must be completed for each patient in full, and accompanied by fully itemized bills. It is not necessary for you to convert currency.

Since any documents you submit cannot be returned, please be sure to keep photocopies of all bills and supporting documentation for your personal records.

International claim form information

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 has other health 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 has received benefits from any other health insurance plan, the Explanation of Benefits Form furnished by the other insurance company pertaining to these charges must be included with the claim.

A clear photocopy of the other insurance company's Explanation of Benefits Form is acceptable in place of the original document.

4. Charges Please list here the bills that are being claimed. Although the original itemized bills must be submitted, your listing will enable us to process the claim more quickly and accurately. 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 or supply – For example: hospital admission, office X-ray, laboratory test, surgery, etc.

4d. Date of service or purchase – Inclusive dates may be indicated for bills containing multiple dates of service (i.e., 1/10/06 – 1/20/06).

4e. Charges: Indicate the total charge for each applicable service or supply.

5. Signature The International Claim Form must be signed and dated by the subscriber, spouse, domestic partner, or the patient. Attach the original itemized bills showing a separate charge for each service. If the bill has already been paid, please indicate.

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 or supply
- The charge for each service or supply

This completed claim form, together with itemized bills and supporting documentation, should be submitted to:

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