Blue Shield of California
An Independent Member of the Blue Shield Association

Blue Shield of California Life & Health Insurance Company
An Independent Licensee of the Blue Shield Association

International Claim Form

Send completed form to:
Blue Shield of California/Blue Shield of California Life & 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.

1. Member Information – 1A. Alpha prefix ___ ___ ___ Identification number *(Copy this from your Blue Shield ID Card)* ___ ___ ___ ___ ___ ___ ___ ___ ___

1B. Patient's name *(First, Middle Initial, Last)*	1C. Patient's date of birth MM/DD/YY / /	1D. Patient's gender ❑ Male ❑ Female
1E. Name of subscriber *(First, Middle Initial, Last)*	1F. Subscriber's date of birth MM/DD/YY / /	1G. Patient's relationship to subscriber ❑ Self ❑ Spouse ❑ Child ❑ Domestic Partner

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 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 MM/DD/YY / /	2D. Termination date MM/DD/YY / /	2E. Policy or identification number of other coverage

2F. Type of Coverage Medical: ❑ Yes ❑ No	2G. Name of contract holder	2H.Date of birth MM/DD/YY / /

2I. Employer of contract holder	2J. Employment status ❑ Active employee ❑ Retired employee

2K. If patient is covered under Medicare, complete the following: Medicare Part A: ❑ Yes ❑ No Medicare Part B: ❑ Yes ❑ No
Effective date ________________ Effective date ________________

3. Diagnosis – 3A. Describe illness, injury, or symptoms requiring treatment

3B. Was patient's condition due to a work-related accident or condition? ❑ Yes ❑ No

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

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. Type of provider	4B. Name of provider	4C. Description of service or supply	4D. Dates of service or purchase	4E. Charges

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 _________________

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 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 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., 1/10/04 – 1/20/04).

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:

Blue Shield of California/Blue Shield of California Life & Health Insurance Company
International Claims
P.O. Box 272550
Chico, CA 95927-2550 USA