Medical Expense

Claim Form and Instructions

BlueCross BlueShield Global Solutions℠

Use this form to submit any eligible medical, dental, vision or prescription claim.

To complete your claim form, make sure you fill in everything in sections 1–5. And don't forget to sign the form. Instructions for sending the form are on the last page. Or, for a quicker and easier way, you can use our eClaims tool using the Member Portal or BCBS Global Solutions™ mobile app.

1 Patient Information

Member ID *(Please enter the Member ID number as shown on card)* _____

Patient's Name *(First name, last name)* _____

Patient's Date of Birth *(MM/DD/YYYY)* _____ **Patient's Sex Recorded at Birth** ○ **Male** ◉ **Female**

Name of Primary Insured *(First name, last name)* _____

Primary Insured's Date of Birth *(MM/DD/YYYY)* _____

Patient's Relationship to Primary Insured ◉ **Self** ○ **Spouse** ○ **Child**

Employer of Primary Insured _____

Primary Insured's Current Mailing Address _____

Primary Insured or Patient's Email _____

Primary Insured or Patient's Phone Number _____

2 Other Health Insurance

Is the patient covered under other health insurance? ○ **Yes** ○ **No** *(If* **YES**, *please complete the following section)*

Name and Address of Other Insurance Company _____

_____

Name of Primary Insured *(First name, last name)* _____

Primary Insured's Date of Birth *(MM/DD/YYYY)* _____

Policy or Identification Number of Other Coverage _____

Policy Effective Date *(MM/DD/YYYY)* _____ **Policy Termination Date** *(MM/DD/YYYY)* _____

3 Diagnosis *(Describe illness, injury or symptoms requiring treatment)*

Was this an auto accident? ○ **Yes** ○ **No**

Was patient's treatment due to an accident? ○ **Yes** ○ **No** *(If* ***YES,*** *please describe the accident below including the date it occurred)*

Was this a work-related accident? ○ **Yes** ○ **No** *(If the accident was caused by someone else, attach a statement describing the accident)*

Description of Diagnosis/Injury _____

_____

4 Charges *(List each type of service or provider in the sections below and attach itemized bills for all services)*

Name, Street, City & Country of Provider Making Charge ______________________________

____

Diagnosis *(i.e. back pain, etc.)* ______________________________

Service or Prescription *(i.e. X-ray, Tylenol, etc.)* ______________________________

Dates of Service *(MM/DD/YYYY)* ______________ **Charges** *(Please indicate currency)* ______________

Name, Street, City & Country of Provider Making Charge ______________________________

____

Diagnosis *(i.e. back pain, etc.)* ______________________________

Service or Prescription *(i.e. X-ray, Tylenol, etc.)* ______________________________

Dates of Service *(MM/DD/YYYY)* ______________ **Charges** *(Please indicate currency)* ______________

Name, Street, City & Country of Provider Making Charge ______________________________

____

Diagnosis *(i.e. back pain, etc.)* ______________________________

Service or Prescription *(i.e. X-ray, Tylenol, etc.)* ______________________________

Dates of Service *(MM/DD/YYYY)* ______________ **Charges** *(Please indicate currency)* ______________

5 Claim Payment Reimbursement

○ **Make Payment to Service Provider** *(If payment is to be paid to the provider, ensure bank information is on the provider invoice)*

○ **Make Payment to Primary Insured**

Reimbursement Method ○ **U.S. Dollar Check** ○ **Bank Wire Transfer** *(Complete the information below)*

When possible, using U.S. bank accounts is recommended to avoid unnecessary fees by the receiving bank. Only wires from U.S. bank accounts will be completed via ACH, which generally reduces or eliminates wire transaction fees.

Currency of Reimbursement ______________________________

Account Holder's Name *(Must be Primary Insured)* ______________________________

Bank Name ______________________________

Bank Address *(Street, City and Country)* ______________________________

____

Bank 9 Digit ABA Number *(U.S. Banks)* ______________________________

Bank 8 or 11 Digit SWIFT Code *(Non-U.S. Banks)* ______________________________

Bank Account Number ______________________ **SORT Code** ______________

Bank IBAN _____

Country Specific Requirements *(TRNO – Canadian Banking, CLABE – Mexican banking, etc.)*

_____

Intermediary Bank Details *(If applicable)*

Name of Intermediary Bank _____

Intermediary Bank SWIFT Code _____

Intermediary Bank Account Number _____

6 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, that participated in any way in the patient's care, to release to Blue Cross Blue Shield Global Solutions℠ 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. If a person is under 18 years of age, this form must be signed by their parent/guardian/school administrator in the space provided below.

Signature of Primary Insured Member or Patient _____ **Date** _____

Fraud Notice

Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution, fines, or confinement in prison, or any combination thereof.

Alaska: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete or misleading information may be prosecuted under state law.

Arizona: For your protection Arizona law requires the following statement to appear on this form: Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

Arkansas, Louisiana, Rhode Island, West Virginia: Any person who knowingly presents a false or fraudulent claim for payment for a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

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

Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

Delaware: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

District of Columbia: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Hawaii: For your protection, Hawaii law requires you be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

Idaho: Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement containing any false, incomplete, or misleading information is guilty of a felony.

Indiana: Any person who knowingly, and with intent to defraud an insurer, files a statement of claim containing false, incomplete or misleading information commits a felony.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Maine, Tennessee, Virginia, Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Minnesota: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

New Hampshire: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud as provided in R.S.A. 638.20.

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New Mexico: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

New York: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed $5,000 and the stated value of the claim for each violation.

Ohio: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Oklahoma: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Texas: Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Instructions for Filing a Claim

The following steps will help you in filing claims. **Please note, incomplete form submissions will delay the processing of your claim(s).**

For Parts 1–4 of the claim form:

- Please submit a **separate claim form** for each patient.
- Please be as descriptive as possible.
- Submitted bills must be **itemized** — canceled check, cash register receipts and non-itemized "balance due" statements **cannot** be processed.
- An itemized bill is a full description of all actual charges and each itemized bill must include:
  - Name and address of provider (doctor, hospital, laboratory, ambulance service, etc.), banking information of provider, name of patient, date(s) of service, amount charged for each service described, diagnosis or reason for treatment.
  - Submitted bills for prescriptions should include the name of the drug, the quantity dispensed and the dosage.

To accurately complete Part 5 of the claim form:

- Payments are made to the **Primary Insured** on the plan. Payments cannot be made directly to a dependent or to a third party (other than the Service Provider).
- For funds sent to an international bank account, the bank IBAN number is mandatory.
- For payments made via wire transfer/ACH, the Primary Insured must be listed as an account holder on the bank account receiving funds.
- **If paying an international provider, invoice must include bank information.**

Send completed claim forms, written inquiries and address changes to:

Claims Incurred Outside of the U.S., Puerto Rico, and U.S. Virgin Islands

Blue Cross Blue Shield Global Solutions
Claims Department
PO Box 1748
Southeastern, PA 19399 - 1748

Claims Incurred Inside of the U.S., Puerto Rico, and U.S. Virgin Islands

Blue Cross Blue Shield Global Solutions
PO Box 21974
Eagan, MN 55121

Claims Submission Fax: **+1 610 482 9623**

Claims Submission Email: **claims@bcbsglobalsolutions.com**

24/7/365 Member Services | Please refer to the number on your ID card.