BlueCross® BlueShield® Blue Crescent℠

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 ☐ Depender

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 selected, 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 (Skip to 5D to authorize reimbursement to be issued to provider)
Requested Currency US Dollars ■ Currency on Bills

5B. SELECT TYPE OF REIMBURSEMENT
Note: Omission or errors in payment information will result in receipt of a check in US Dollars.
Check ■ Electronic Transfer

5C. COMPLETE FOR ELECTRONIC FUND TRANSFER

Name on Bank Account (Contract Holder) American Medical Center

Bank Name Kreissparkasse Kusel

Complete Bank Address (Street)

City ____ State ____ Zip Code ____ Country ____

Routing Number (ABA/ACH) M A L A D E 5 1 K U S

Account Number (Local Bank/IBAN) D E 1 6 5 4 0 5 1 5 5 0 0 0 0 0 9 8 0 8 1 3

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

Provider Name American Medical Center-Primary Care

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) ____