

BlueCard Worldwide[®] International Claim Form



Blue Cross and Blue Shield Plans are independent licensees of the Blue Cross and Blue Shield Association.

Please see the instructions on the reverse side of this form before completing. Please type or print.

Send completed form to: BlueCard Worldwide Service Center
P.O. Box 72017
Richmond, VA 23255-2017 USA

1. Patient Information— 1A. Alpha prefix Identification number *Copy this from your Blue Cross Blue Shield identification card.*

XYZ 1 2 3 4 5 6 7 8 9

| | | |
|---|---|--|
| 1B. Patient's name (First, middle initial, last) <u>CHRIS A. HILL</u> | 1C. Patient's date of birth MM/DD/YYYY <u>03 / 15 / 1960</u> | 1D. Patient's sex <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female |
| 1E. Name of subscriber (First, middle initial, last) <u>CHRIS A. HILL</u> | 1F. Subscriber's date of birth MM/DD/YYYY <u>03 / 15 / 1960</u> | 1G. Patient's relationship to subscriber <input checked="" type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child |

1H. Subscriber's current mailing address (Street, city, state, and country or ZIP code)
45 FOREST AVENUE, CHICAGO, ILLINOIS 60601 USA

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 insuring company

| | | | |
|--|--|---|--|
| 2B. Type of policy <input type="checkbox"/> Family <input type="checkbox"/> Individual | 2C. Effective date MM/DD/YYYY / / | 2D. Termination date MM/DD/YYYY / / | 2E. Policy or identification number of other coverage |
| 2F. Type of coverage Hospital: <input type="checkbox"/> Yes <input type="checkbox"/> No Medical: <input type="checkbox"/> Yes <input type="checkbox"/> No Mental illness: <input type="checkbox"/> Yes <input type="checkbox"/> No | 2G. Name of subscriber | | 2H. Date of birth MM/DD/YYYY / / |
| 2I. Employer of subscriber | 2J. Employment status <input type="checkbox"/> Active employee <input type="checkbox"/> Retired employee | | |

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

3. Diagnosis— 3A. Describe illness, injury, or symptoms requiring treatment
STREP THROAT, DIFFICULTLY SWALLOWING AND FEVER

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

3C. Complete for care related to accidental injuries

Date of accident _____ Location: At home Auto Other _____
Time of accident _____ *If the accident was caused by someone else, attach a statement describing the accident.*

4. Charges— Use a separate line to list each type of service or provider and attach itemized bills for all services.

| 4A. Name and address of provider making charge | 4B. Type of provider | 4C. Description of service | 4D. Dates of service or purchase | 4E. Charges |
|---|---|----------------------------|----------------------------------|---------------|
| <u>DR. JOHN SMITH 28 NORTH AVENUE LONDON, UK E1 4DG</u> | <u>PHYSICIAN (GENERAL PRACTICE)</u> | <u>CONSULTATION</u> | <u>8/1/06</u> | <u>GBP 50</u> |

5. Payee— Select one of the following payment options:

5A. Make payment to subscriber; provider has been paid.

1. Currency— Do you want the check issued in the currency reflected on the itemized bill(s) or in U.S. dollars? Currency on itemized bill(s) U.S. dollars

2. Payment Method – Do you want to receive payment via a check or bank wire? Check Provide current telephone number _____
 Bank Wire. If you want to receive a bank wire provide the following:
Subscriber name as it appears on bank account: CHRIS A. HILL Bank name XYZ BANK
Bank's Physical Address 100 LASALLE STREET, CHICAGO, IL 60602
Account # 12345678 ABA# ABCDEFGHIJ

5B. Make payment to provider (hospital, doctor). Please complete and sign.

Authorization for Assignment of Benefits
I, the undersigned, authorize and request Blue Cross and Blue Shield to make payment for benefits due herein to:
Name of provider _____ Signature of subscriber or spouse _____ Date _____

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 the subscriber's Blue Cross and Blue Shield Plan 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 the subscriber's Blue Cross and Blue Shield Plan 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 C. Hill Date 09 / 01 / 2006