BlueCross®
BlueShield®
Blue Crescent℠

Federal Employee Program
OVERSEAS CLAIM FORM

Please see the instructions on the reverse side of this form before completing
PLEASE TYPE OR PRINT.

A. ENROLLMENT CODE 1 0 | **IDENTIFICATION NUMBER** R

1. PATIENT INFORMATION

B. PATIENT'S NAME *(First, Middle Initial, Last)*

C. PATIENT'S DATE OF BIRTH Month / Day / Year

D. PATIENT'S SEX ☐ *Male* ☐ *Female*

E. NAME OF SUBSCRIBER OR POLICY HOLDER *(First, Middle Initial, Last)*

F. SUBSCRIBER'S DATE OF BIRTH Month / Day / Year

G. PATIENT'S RELATIONSHIP TO SUBSCRIBER ☐ *Self* ☐ *Spouse* ☐ *Child*

If the patient's last name is different from the subscriber's, please attach a statement explaining the relationship

H. 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? ( ) Yes (X) No
If yes, complete items A through J below.

A. Name and Address of Insuring Company

B. Type of Policy ( ) Family ( ) Individual

C. Effective Date Month / Day / Year

D. Termination Date Month / Day / Year

E. Policy or Identification Number of Other Coverage

F. Type of Coverage — Medical ( ) Yes ( ) No; Dental ( ) Yes ( ) No; Mental Illness ( ) Yes ( ) No

G. Name of Policy Holder

H. Date of Birth

I. Employer of Policy Holder

J. Employment Status ( ) Active Employee ( ) Retired Employee

3. MEDICARE

Complete this section regardless of the patient's age.

If you are covered by a Medicare HMO/Prepaid Plan, please leave Sections A and B blank

A. Medicare Part A ( ) Yes ( ) No Effective Date

B. Medicare Part B ( ) Yes ( ) No Effective Date

C. Medicare HMO/Prepaid Plan ( ) Yes ( ) No Effective Date

D. Medicare ID #

E. Is the Subscriber an active Federal Employee? ( ) Yes ( ) No
Is the patient an active Federal Employee? ( ) Yes ( ) No

F. End Stage Renal patients, please indicate the beginning date of renal treatment. Month / Day / Year

4. DIAGNOSIS

A. Describe illness, injury, or symptoms requiring treatment.

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

C. Complete for care related to accidental injuries.
DATE OF ACCIDENT _____ TIME OF ACCIDENT _____
LOCATION ( ) at home ( ) auto ( ) other _____
If the accident was caused by someone else, attach a statement describing the accident.

5. 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 bills for all services claimed.

A. TYPE OF PROVIDER	B. NAME OF PROVIDER MAKING CHARGE	C. DESCRIPTION OF SERVICE	D. DATES OF SERVICE OR PURCHASE	E. CHARGE
	FIRSTMED-FMC KFT. 1015 BUDAPEST, HATTYÚ UTCA 14.			

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, 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.

X _____
Signature of Subscriber or Patient

_____
Date

7. AUTHORIZATION FOR ASSIGNMENT OF BENEFITS

I, the undersigned, authorize and request CareFirst BlueCross BlueShield to make payment for benefits due herein to:

FIRSTMED-FMC KFT.
Name of Provider

X _____
Signature of Subscriber or Spouse

_____
Date

FEDERAL EMPLOYEE PROGRAM OVERSEAS CLAIM FORM

GENERAL INFORMATION
This Overseas Claim Form is to be used to submit a claim for benefits for covered services received outside the United States and Puerto Rico. Please complete a separate claim form for each patient and remember to file all claims by December 31 of the calendar year after the one in which the covered care or service was provided.

The Overseas Claim Form must be completed in full, and accompanied by fully itemized bills. **If any bills or supporting information are written in a language other than English, please provide an English translation of those documents**.

Since the claim cannot be returned, please be sure to keep photocopies of all bills and supporting documentation for your personal records.

OVERSEAS 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 holds other insurance coverage, please complete items A through J 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 is someone other than the Subscriber and has received benefits from any other health insurance Plan held by reason of law or employment, the Explanation of Benefits Form furnished by the other carrier pertaining to these charges must be included with the claim. A clear photocopy of the other carrier's Explanation of Benefits Form is acceptable in place of the original document.

3. **MEDICARE** – Medicare benefits are not provided for services received in foreign countries. However, the calendar year deductible and coinsurance are waived for Federal Employee Program Subscribers who are also enrolled in Medicare Part B. Therefore, please complete item 3 regardless of the patient's age.

5. **CHARGES** – Please list here the bills that are being included on this claim. Although itemized bills must also be submitted, your listing will enable us to process the claim more quickly and accurately. If additional space is needed for listing charges, please use a separate sheet of paper to list the following information.

   A. TYPE OF PROVIDER – for example: hospital, nurse, physician, dentist, pharmacy, physical therapist, etc.

   B. NAME 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 types of service.

   C. DESCRIPTION OF SERVICE – for example: hospital admission, office visit, dental care, x-ray, laboratory test, surgery, prescription drug, etc.

   D. DATE OF SERVICE OR PURCHASE – inclusive dates may be indicated for bills containing multiple dates of service.

   E. CHARGE – Bills must be itemized to show a separate charge for each service. If the bill has already been paid, please indicate the date it was paid.

6. **SIGNATURE** – The Overseas Claim Form must be signed and dated by the Subscriber, spouse, or the patient.

7. **AUTHORIZATION FOR ASSIGNMENT OF BENEFITS** – Complete item 7 if you prefer that benefits be paid directly to the provider of service.

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
– The charge for each service
– Drug and medicine bills prescribed for use outside the hospital must also show the generic name of the medicine, or the name under which it may be purchased in the United States.

THIS COMPLETED CLAIM FORM, TOGETHER WITH ITEMIZED BILLS AND SUPPORTING DOCUMENTATION, SHOULD BE SUBMITTED TO:

CAREFIRST BLUECROSS BLUESHIELD
550 12TH STREET, S.W.
WASHINGTON, D.C. 20065

Attention: FEP Overseas Claims Unit