# MEDICAL EXPENSE
Claim Form and Instructions

GeoBlue
GeoBlue is the trade name of Worldwide Insurance Services, LLC, an independent licence of the Blue Cross and Blue Shield Association.

## 1. PATIENT INFORMATION

| **Member ID** | *Please enter Member ID as shown on card* | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|

| Patient's Name *(Given Name, Family Name)* | Patient's date of birth (MM/DD/YYYY) | Patient's Gender | | | |
|---|---|---|---|---|---|
| | | ○ | *Male* | ○ | *Female* |

| Name of Insured Member *(Given Name, Family Name)* | Insured's date of birth (MM/DD/YYYY) | Patient's Relationship to Insured | | | | | |
|---|---|---|---|---|---|---|---|
| | | ○ | *Self* | ○ | *Spouse* | ○ | *Child* |

| **Employer of Insured Member** | Insured's current mailing address |
|---|---|
| | |
| Member Email | Member Phone Number |
| | |

## 2. OTHER HEALTH INSURANCE

| Is the patient covered under other health insurance? | ○ | *Yes* | ○ | *No* | *If YES, please complete this section* |
|---|---|---|---|---|---|

| Name and address of other insurance company | Name of the Policy Holder |
|---|---|
| | |

| Policy Holder's Date of Birth | Policy or identification number of other coverage | Effective Date (MM/DD/YYYY) | Termination Date (MM/DD/YYYY) |
|---|---|---|---|
| | | | |

## 3. DIAGNOSIS – *describe illness, injury or symptoms requiring treatment in the space below*

| 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* |

## 4. CHARGES – *use a separate line to list each type of service or provider and attach itemized bills for all services*

| Name, City & Country of provider making charge | Diagnosis | Description of service | Dates of Service | Charges |
|---|---|---|---|---|
| | | | | |
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## 5. PAYMENT DETAILS

| ○ | Make payment to the provider | *If payment is to be paid to the provider, please ensure bank information is on the provider invoice* | | | | |
|---|---|---|---|---|---|---|
| ○ | Make payment to Primary Insured | Reimbursement Method: | ○ | US Dollar Check | ○ | Bank Wire Transfer (complete below) |

*When possible, utilizing US bank accounts is recommended to avoid unnecessary fees by the receiving bank. U.S. bank accounts (only) wires will be completed via ACH which generally eliminates or reduces wire transaction fees.*

| Account Holder's Name – *Must be: Principal Member (Policyholder)* | Bank Name | |
|---|---|---|
| | | |
| Bank Address - City & Country | Currency of Reimbursement | Bank 9 digit ABA Number - *US Banks* |
| | | |

| Bank 8 or 11 digit SWIFT Code - *NON-US Banks* | Bank Account Number | SORT Code | Bank IBAN |
|---|---|---|---|
| | | | |

| **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 GeoBlue 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 applicable concerning personal information may differ among countries. Please see the back of this from for important information.*

| Signature of Insured member or patient | | Date | |
|---|---|---|---|

## FRAUD NOTICE

**General Fraud Warning** –
Any person who knowingly and with intent to defraud, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

## INSTRUCTIONS FOR FILING A CLAIM

The following steps will assist you in filing claims. **Please note that submitting an incomplete form will result in the delay of processing your claim.**

**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.), 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, Payment Details:**

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

## SEND COMPLETED CLAIM FORMS, WRITTEN INQUIRIES AND ADDRESS CHANGES TO THE ADDRESS BELOW

GeoBlue

**Claims Department**
**PO Box 1748, Southeastern, PA 19399-1748**

Claims Submission Fax: **1.610.482.9623**
Claims Submission Email: **claims@geo-blue.com**

| **24/7 Member Services:** | Outside the U.S.: **+1-610-254-5830** | Toll Free Within the U.S.: **1-888-412-6403** |
|---|---|---|