BlueCross BlueShield Blue Crescent℠

Federal Employee Program

OVERSEAS MEDICAL CLAIM FORM

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

A. ENROLLMENT CODE: 1 | IDENTIFICATION NUMBER: R

1. PATIENT INFORMATION

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

C. PATIENT'S DATE OF BIRTH

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 ☐ Dependent

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

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 ( )

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, e.g. cough, sore throat.

B. Was patient's treatment due to a work-related accident or condition? ( ) Yes ( ) 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
Pediatrics	Dr Schmitt Dr Seipenbusch			

6. MEMBER PAYMENT INFORMATION

Select one from each of the following payment options:
Payment Method: ☐ Check ■ Bank Wire
Currency: ☐ U.S. Dollars ■ Currency on itemized bill

6A. BANK WIRE INFORMATION

Please complete if you selected Bank Wire Payment:

Name on Bank Account: Dr Schmitt Dr Seipenbusch

Bank Name: Kreissparkasse

Bank Physical Address: Kaiserslautern

ABA#

(IBAN)# DE67540502200000575779

(BIC/SWIFT) MALADE51KLK

International Bank Account/ Bank Identifier Code

6B. AUTHORIZATION FOR ASSIGNMENT OF BENEFITS

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

Pediatric Castle Dr Schmitt Dr Seipenbus
Name of Provider

Signature of Subscriber or Spouse ______ Date ______

7. 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.

Date ______

Signature of Subscriber or Patient ______ Home Phone Number ______