BlueCard Worldwide®
International Claim Form

BlueCross® BlueShield®

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 or ihc@mondialusa.com
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.*

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1B. Patient's name (First, middle initial, last)	1C. Patient's date of birth MM/DD/YYYY / /	1D. Patient's sex ☐ Male ☐ Female
1E. Name of subscriber (First, middle initial, last)	1F. Subscriber's date of birth MM/DD/YYYY / /	1G. Patient's relationship to subscriber ☐ Self ☐ Spouse ☐ Child

1H. 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, including Medicare A or B? ☐ Yes ☐ No
If yes, complete 2A through 2K below.

2A. Name and address of other insuring company

2B. Type of policy ☐ Family ☐ 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 Medical: ☐ Yes ☐ No Hospital: ☐ Yes ☐ No Mental illness: ☐ Yes ☐ No	2G. Name of subscriber	2H. Date of birth MM/DD/YYYY / /

2I. Employer of subscriber | **2J. Employment status** ☐ Active employee ☐ 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 and onset date of symptoms or injury.

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
MVZ-RADIOLOGIE	RADIOLOGIE			
Bahnstrasse 108				
66849 Landstuhl				

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

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

1. **Currency** – Please check your preference for payment: ☒ **Currency on itemized bill(s)** ☐ **U.S. dollars**
2. **Payment Method** – Please select your preference for how to receive your payment: ☐ **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: Dr Schmitt Dr Seipenbusch Bank name: Kreissparkasse

Bank's Physical Address: Kaiserslautern Account #: _____

ABA# L L L L L L L L L *International Bank Account (IBAN) #: DE67540502200000575779

*Bank Identifier Code (BIC/SWIFT) MALADE51KLK ** Required for bank wires to European Union countries.*

5B. ☒ Make payment to provider (hospital, doctor), if appropriate. Please complete and sign to authorize direct payment to provider.

I, the undersigned, authorize and request payment for benefits due herein to be made to the following provider of services, if such direct payment is deemed appropriate by Blue Cross and Blue Shield:

Name of provider Dr Schmitt Dr Seipenbusch 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, adjudicate a claim or as otherwise described in such Blue Cross and Blue Shield Plan's Notice of Privacy Practices.

Signature of subscriber or patient _____ Date _____