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

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)

1I. Patient's e-mail address

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 Par t B: Yes No Effecti ve 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 _____

General Information

- The Blue Cross Blue Shield Global Core International Claim Form is to be used to submit institutional and professional claims for benefits for covered services received outside the United States, Puerto Rico and the U.S. Virgin Islands.
- For other claim types (e.g., dental, prescription drugs), contact your Blue Cross and Blue Shield Company for filing instructions.
- Please complete all fields. If the information requested does not apply to the patient, indicate N/A (Not Applicable).
- Please attach receipts and medical records (test results, x-rays, etc.), if available.
- Please keep photocopies of all documentation for your personal records.

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