Claim Form and Instructions

GeoBlue

GeoBlue is the trade name of Worldwide Insurance Services, LLC (Worldwide Services Insurance Agency, LLC in California and New York), an independent licensee of the Blue Cross and Blue Shield Association.

1. PATIENT INFORMATION

Member ID *Please enter the Member ID number as shown on card*		
Patient's Name (*Given name, family name*)	**Patient's Date of Birth** (*MM/DD/YYYY*)	**Patient's Sex Recorded at Birth**
		○ Male ○ Female
Name of Primary Insured (*Given name, family name*)	**Primary Insured's Date of Birth** (*MM/DD/YYYY*)	**Patient's Relationship to Primary Insured**
		○ Self ○ Spouse ○ Child
School/University/Program Sponsor of Primary Insured	**Primary Insured's Current Mailing Address**	
Primary Insured or Patient's Email	**Primary Insured or Patient's Phone Number**	

2. OTHER HEALTH INSURANCE

Is the patient covered under other health insurance? ○ YES ○ NO		***If YES,*** *please complete the following section:*	
Name and Address of Other Insurance Company		**Name of Primary Insured** (*Given name, family name*)	
Primary Insured's Date of Birth (*MM/DD/YYYY*)	**Policy or Identification Number of Other Coverage**	**Policy Effective Date** (*MM/DD/YYYY*)	**Policy Termination Date** (*MM/DD/YYYY*)

3. DIAGNOSIS *(Describe illness, injury or symptoms requiring treatment.)*

IF IN AN ACCIDENT/INJURY

Date of Accident (MM/DD/YYYY)		**Place of Accident**			
Date of Doctor/Hospital Visit (*MM/DD/YYYY*)		**Was the injury a result of participation in an Intercollegiate Sport?**	○ YES ○ NO	**Was this an Auto Accident?**	○ YES ○ NO

Description/Details of Injury *(Attach additional notes if necessary)*

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	Description of Service (*Office Visit, X-ray, Prescription, etc.*)	Dates of Service (*MM/DD/YYYY*)	Charges (*Please indicate currency*)

5. CLAIM PAYMENT REIMBURSEMENT

Make Payment to Primary Insured – Payment Will Be Made to Primary Insured via Check	*Payable in U.S. dollars and mailed to the address indicated above*
Make Payment to Provider – Payment Will Be Made to Service/Medical Provider	*If payment is to be paid to the provider, please ensure bank information is on the provider invoice*
Make Payment to Third Party	*Will require Third Party Reimbursement form to be completed; please ensure bank information is provided on form*

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 that applicable law concerning personal information may differ among countries. If a person is under 18 years of age, this form must be signed by their parent/guardian/school administrator in the space provided below. Please see the back of this form for important information.

Signature of Primary 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.

THIRD PARTY REIMBURSEMENT

Third Party Reimbursement
All payments will be made to the Primary Insured if the transportation/lodging bills have been paid by you. If you would like a third party to receive reimbursement for covered expenses under this policy, you must request a Third Party Reimbursement Form from GeoBlue Member Services.

Authorization for Third Party Reimbursement is voluntary. Any documentation accompanying a payment or otherwise could contain federal and/or state Protected Health Information and other protected private or financial information. Protected Health Information means health data that could be used to individually identify you including your name, address and specific medical material and facts.

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 claimant.
- 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 Insured** on the plan. Payments cannot be made directly to a dependent or a third party (other than the Service Provider) unless you complete a Third Party Reimbursement form.
- Providers in the U.S., Puerto Rico and the U.S. Virgin Islands should bill their local Blue Cross® Blue Shield® Plan directly.
- **If paying an international provider, invoice must include bank information**.

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

Claims Incurred Outside the U.S., Puerto Rico, and U.S. Virgin Islands

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

Claims Submission Fax: **1-610-482-9623**
Claims Submission Email: **claims@geo-blue.com**

Claims Incurred Inside the U.S., Puerto Rico, and U.S. Virgin Islands

GeoBlue
PO Box 21974
Eagan, MN 55121

Claims Submission Fax: **1-610-482-9623**
Claims Submission Email: **claims@geo-blue.com**

24/7/365 Member Services:

Inside the U.S.: 1-844-268-2686 **Outside the U.S.: +1-610-263-2847**