CLAIM FORM
GROUP POLICY
285630

afspa FOREIGN SERVICE BENEFIT PLAN *Caring For Your Health Worldwide*

aetna

☐ CHECK HERE IF NEW ADDRESS SINCE LAST SUBMISSION. DATE RELOCATED ___/___/___

FORWARD COMPLETED CLAIM FORM TO: **FOREIGN SERVICE BENEFIT PLAN**
1620 L STREET, NW, SUITE 800
WASHINGTON, DC 20036-5629

Phone: (202) 833-4910

PLEASE PRINT — **TO BE COMPLETED BY INSURED MEMBER** — **PLEASE PRINT**

All items must be answered in full before your claim can be processed.

Member's full name _____ Date of Birth _____

Member's mailing address _____
(Number and Street) (City) (State) (Zip Code)

Member's Subscriber ID _____ Enrollment Code ☐ Self Only 401 ☐ Self Plus One 403 ☐ Self & Family 402

If claim is for a dependent, given name _____ Relationship _____ Date of Birth _____

Dependent's marital status (check one) ☐ single ☐ married

Name of dependent's employer _____

Describe Sickness/Accident Suffered _____

If Accident: (a) Date of accident _____
(Month) (Day) (Year) (Hour)

(b) How and where did accident occur? _____

Was accident or sickness work related? ☐ Yes ☐ No If "Yes" please contact your workers' compensation office for guidance.

Physician's Name _____ Address _____

OTHER INSURANCE/MEDICARE COVERAGE INFORMATION

(See section on coordination of benefits in your Brochure)

IMPORTANT: This question must be answered and the form signed before claim can be processed.

(a) Are you or any member of your family covered under any health plan other than FOREIGN SERVICE BENEFIT PLAN? ☐ Yes ☐ No

(b) If answer is "Yes", complete the following:

Person in whose name the other plan is issued _____

Name of all dependents covered under the other plan _____

Name of Insurance Company or Plan _____ Effective Date _____

Address of Claims Office _____

Is this insurance through active employment? _____ Employment Effective Date _____

Policy or Contract Number _____ Is Plan ☐ Family or ☐ Self only coverage? (Check appropriate block)

(c) Is this other plan issued under a ☐ Group or ☐ Individual contract? (Check appropriate block)

IMPORTANT: This question must be fully answered by persons age 65 or older and persons under age 65 receiving disability benefits through Social Security.

Medicare coverage (see your official Brochure)

(a) Are you or any member of your family covered under Medicare? ☐ Yes ☐ No

(b) If "Yes", indicate name of person and check the type of coverage.

SELF: _____ ☐ Hospital (Part A) Effective Date _____ ☐ Medicare (Part B) Effective Date _____

SPOUSE: _____ ☐ Hospital (Part A) Effective Date _____ ☐ Medicare (Part B) Effective Date _____

DEPENDENT: _____ ☐ Hospital (Part A) Effective Date _____ ☐ Medicare (Part B) Effective Date _____

(c) If you or your spouse are 65 or over, indicate whether you are actively employed.

Self: ☐ Yes ☐ No Employer _____

Spouse: ☐ Yes ☐ No Employer _____

Authorization for direct payment of benefits.	I authorize payment directly to _____ (Print name of physician) for the Medical and/or Surgical Benefits otherwise payable to me. Date _____, 20 _____ Signed _____ (Signature of member)

I certify the information on this form is complete and accurate.

Signature of patient or member	Date

WARNING: Any intentional false statement in this application or willful misrepresentation relative thereto is a violation of the law punishable by a fine of not more than $10,000, or imprisonment of not more than five years, or both. (18 U.S.C. 1001)

HAVE YOU ANSWERED EVERY QUESTION? _____ **HAVE YOU DATED AND SIGNED THIS FORM?** _____

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA | PICA

CARRIER

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) TRICARE ☐ (ID #/DoD#) CHAMPVA ☐ (Member ID #) GROUP HEALTH PLAN ☐ (ID #) FECA BLK LUNG ☐ (ID #) OTHER ☐ (ID #)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

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

3. PATIENT'S BIRTH DATE MM DD YYYY

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (Number, Street)

6. PATIENT'S RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (Number, Street)

CITY | STATE

8. RESERVED FOR NUCC USE

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (Include Area Code) ( )

PATIENT AND INSURED INFORMATION

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

a. OTHER INSURED'S POLICY OR GROUP NUMBER

b. RESERVED FOR NUCC USE

c. RESERVED FOR NUCC USE

d. INSURANCE PLAN NAME OR PROGRAM NAME

10. IS PATIENT'S CONDITION RELATED TO:

a. EMPLOYMENT? (Current of Previous) ☐ YES ☐ NO

b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State)

c. OTHER ACCIDENT? ☐ YES ☐ NO

10d. CLAIM CODES (Designated by NUCC)

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. INSURED'S DATE OF BIRTH MM DD YYYY

b. OTHER CLAIM ID (Designated by NUCC)

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO ***If yes***, complete items 9, 9a and 9d

SECOND FOLD

12. PATIENT'S OR AUTHORIZED PERSON'S Signature I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT ILLNES, INJURY or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE MM DD YY QUAL.

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES

FIRST FOLD WHCF-10 ENV / WHCF-10-ENV-SS

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24E)) ICD Ind.

A. B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID QUAL	J. RENDERING PROVIDER ID #
1									NPI	
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NUMBER

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☐ YES ☐ NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC use

31. SIGNATURE OF PHYSICAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. **NPI** b.

33. BILLING PROVIDER INFO & PH. # ( )

a. **NPI** b.

NUCC Instruction Manual Available at: **www.nucc.org** **PLEASE PRINT OR TYPE** APPROVED OMB 0938-1197 FORM 1500 (02-12)

WCMS-1500CS-1

TTY: **711**

English	**To access language services at no cost to you, call the number on your ID card.**
Amharic	የቋንቋ አገልግሎቶችን ያለክፍያ ለማግኘት፣ በመታወቂያዎት ላይ ያለውን ቁጥር ይደውሉ፡፡
Arabic	للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء الصال على الرقم الموجود على بطاقة اشتراكك.
Armenian	Ձեր նախընտրած լեզվով ավվճար խորհրդատվություն ստանալու համար զանգահարեք ձեր բժշկական ապահովագրության քարտի վրա նշված հէրախոսահամարով հէրախոսահամարով
Carolinian (Kapasal Falawasch)	Ngir mëna am sarwis lakk yi te doo fay, woo nimero bi am ci sa kàrt.
Chamorro	Para un hago' i setbision lengguåhi ni dibåtde para hågu, ågang i numiru gi iyo-mu kard aidentifikasion.
Chinese Traditional	如欲使用免費語言服務，請撥打您健康保險卡上所列的電話號碼
Cushitic-Oromo	Tajaajiiloota afaanii gatii bilisaa ati argaachuuf, lakkoofsa fuula waraaqaa eenyummaa (ID) kee irraa jiruun bilbili.
French	Pour accéder gratuitement aux services linguistiques, veuillez composer le numéro indiqué sur votre carte d'assurance santé.
French Creole (Haitian)	Pou ou jwenn sèvis gratis nan lang ou, rele nimewo telefòn ki sou kat idantifikasyon asirans sante ou.
German	Um auf den für Sie kostenlosen Sprachservice auf Deutsch zuzugreifen, rufen Sie die Nummer auf Ihrer ID-Karte an.
Greek	Για πρόσβαση στις υπηρεσίες γλώσσας χωρίς χρέωση, καλέστε τον αριθμό στην κάρτα ασφάλισής σας.
Gujarati	તમારે કોઇ પણ તના ખર્ચ ના ભાષા સેવાઓ મેળવવા માટે, તમારા આઇ કાડપર રહેલ નંબર પર કૉલ કરવો.
Hindi	बना कसी कमत के भाषा सेवाआ का उपयोग करने के लए, अपने आइड काडर् पर दए नंबर पर कॉल कर।
Hmong	Yuav kom tau kev pab txhais lus tsis muaj nqi them rau koj, hu tus naj npawb ntawm koj daim npav ID.
Italian	Per accedere ai servizi linguistici senza alcun costo per lei, chiami il numero sulla tessera identificativa.
Japanese	無料の言語サービスは、IDカードにある番号にお電話ください。
Karen	လၢကမၤန့ၢ် ကျိာ်တၢ်မၤစၢၤတၢ်မၤ လၢတလိာ်လက်ဘူဉ်လက်စ့ၤ လၢနဂီၢ်အဂီၢ်, ကိးနီၣ်ဂံၢ် လၢအအိၣ် ဖဲန ID အဖီခိၣ်နှၣ်တက့ၢ်.
Korean	무료 다국어 서비스를 이용하려면 보험 ID 카드에 수록된 번호로 전화해 주십시오.
Laotian	ເພື່ອເຂົ້າເຖິງບໍລິການພາສາທີ່ບໍ່ເສຍຄ່າ, ໃຫ້ໂທຫາເບີໂທຢູ່ໃນບັດປະຈຳຕົວຂອງທ່ານ.
Mon-Khmer, Cambodian	ដើម្បីទទួលបានសេវាកម្មភាសាដែលឥតគិតថ្លៃសម្រាប់លោកអ្នក សូមទូរស័ព្ទទៅកាន់លេខដែលមាននៅលើបណ្ណសម្គាល់ខ្លួនរបស់លោកអ្នក។
Navajo	T’áá ni nizaad k’ehjí bee níká a’doowoł doo bą́ą́h ílínígóó naaltsoos bee atah nílį́įgo nanitinígíí bee néého’dólzinígíí béésh bee hane’í biká’ígíí áajj’ hólne’.
Pennsylvanian-Dutch	Um Schprooch Services zu griege mitaus Koscht, ruff die Nummer uff dei ID Kaart.
Persian-Farsi	برای دسترسی به خدمات زبان به طور رایگان، با شماره قید شده روی کارت شناسایی خود تماس بگیرید.
Polish	Aby uzyskać dostęp do bezpłatnych usług językowych, należy zadzwonić pod numer podany na karcie identyfikacyjnej.
Portuguese	Para aceder aos serviços linguísticos gratuitamente, ligue para o número indicado no seu cartão de identificação.
Punjabi	ਤੁਹਾਡੇ ਲਈ ਬਿਨਾ ਕਿਸੇ ਕੀਮਤ ਵਾਲੀਆ ਪੰਜਾਬੀ ਸੇਵਾਵਾ ਦੀ ਵਰਤੋ ਕਰਨ ਲਈ, ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ ‘ਤੇ ਦਿੱਤੇ ਨੰਬਰ 'ਤੇ ਫ਼ੋਨ ਕਰੋ।
Russian	Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону, приведенному на вашей идентификационной карте.
Samoan	Mō le mauaina o 'au'aunaga tau gagana e aunoa ma se totogi, vala'au le numera i luga o lau pepa ID.
Serbo-Croatian	Za besplatne prevodilačke usluge pozovite broj naveden na Vašoj identifikacionoj kartici.
Spanish	Para acceder a los servicios lingüísticos sin costo alguno, llame al número que figura en su tarjeta de identificación.
Syriac-Assyrian	ܐܢ ܒܥܝܬܘܢ ܕܡܛܝܬܘܢ ܠܚܫ̈ܚܬܐ ܕܠܫܢܐ ܡܓܢ, ܩܪܘ ܠܡܢܝܢܐ ܥܠ ܟܪܛܝܣ ܕܗܝܝܘܬܐ ܕܝܠܟܘܢ.
Tagalog	Upang ma-access ang mga serbisyo sa wika nang walang bayad, tawagan ang numero sa iyong ID card.
Thai	**หากท่านต้องการเข้าถึงการบริการทางด้านภาษาโดยไม่มีค่าใช้จ่าย โปรดโทรหมายเลขที่แสดงอยู่บนบัตรประจำตัวของท่าน**
Ukrainian	Щоб безкоштовнј отримати мовні послуги, задзвоніть за номером, вказаним на вашій ідентифікайній картці.
Vietnamese	Để sử dụng các dịch vụ ngôn ngữ miễn phí, vui lòng gọi số điện thoại ghi trên thẻ ID của quý vị.