AFS Intercultural Programs
Medical Claim Form

SUBMIT CLAIM FORM TO:
GLOBAL BENEFITS, INC.
1250 24th St. NW, Ste 300
Washington, DC 20005
(800) 633-1860 • (202) 898-0944

PLEASE READ THIS IMPORTANT INFORMATION
- Healthcare providers submitting claims directly to Global do not have to complete this form.
- Host family or participant should complete this form if requesting reimbursement for bills already paid by them. If you are given a copy of the industry standard HCFA-1500 or UB-92 Form by the healthcare provider, attach it to this form. If you do so, there is no need to complete the "physician or supplier" section on the back page of this form.
- Reimbursement requests for prescription medications must be accompanied by the original prescription receipt. The prescription receipt is the tag/label that comes attached to the medication containing the student name, doctor/medicine/pharmacy name, date filled, cost, etc.

PARTICIPANT STATEMENT

PARTICIPANT NAME (FIRST)
(LAST)
PARTICIPANT ID # DATE OF BIRTH (mm/dd/yyyy)
PARTICIPANT'S COUNTRY OF ORIGIN PROGRAM START DATE (MONTH/YR)

HOST FAMILY'S NAME
STREET ADDRESS
CITY STATE ZIP
( )
HOST FAMILY'S TELEPHONE

SERIOUS illness, injury or accident MUST be reported to your AFS Regional Service Center immediately by telephone (1-800-876-2377) with date when accident/illness occurred, name, address and telephone numbers of attending physician and hospital/clinic. Serious cases are motor vehicle accidents, hospitalizations, broken bones, etc. Please consult your HANDBOOK, then complete the form and mail to Global Benefits, Inc.

MINOR illness or injury should be described fully on this form and mailed to Global Benefits, Inc. on the same day illness or injury occurred.

Is this illness related to any condition existing prior to arrival in the U.S.? ❑ Yes ❑ No

PHYSICIAN
NAME
ADDRESS
CITY STATE ZIP
( )
TELEPHONE

HOSPITAL/CLINIC
NAME
ADDRESS
CITY STATE ZIP
( )
TELEPHONE

DATE OF ILLNESS THIS DATE PROVIDER'S TAX ID #

ATTENDING PHYSICIAN (IF DIFFERENT FROM ABOVE) ( ) TELEPHONE NUMBER

ADDRESS CITY STATE ZIP

PAYMENT OF MEDICAL BILL
Is the participant covered by a school or other insurance? ❑ Yes ❑ No (If yes, give name and address)

NAME ADDRESS

CITY STATE ZIP

Please check: ❑ No bill expected ❑ Bill(s) will be forwarded ❑ Bill(s) enclosed and should be paid directly
❑ Paid bills with cancelled check(s) and/or receipts enclosed

PERSON TO BE REIMBURSED *All reimbursement checks payable to participants are issued in US currency and made out to the participant's name with the host family address.
NAME
ADDRESS
CITY STATE ZIP
( )
TELEPHONE

I certify that the preceding statements and answers, and the attached bills and/or statements are true and complete to the best of my knowledge. I authorize the release of information and medical records to Global Benefits, Inc. containing the diagnosis and treatment provided to me. I understand that this information will be held confidential.

SIGNATURE DATE (mm/dd/yyyy)

(OVER)

ACCIDENT (Complete only if claim is due to accident)

Note: In the event of a car accident provide a police report.

DATE OF ACCIDENT | TIME OF ACCIDENT

HOW DID THE ACCIDENT HAPPEN?

WHERE DID THE ACCIDENT HAPPEN?

NAME OF INSURANCE OF OTHER PARTIES INVOLVED

ADDRESS OF INSURANCE OF OTHER PARTIES INVOLVED | CITY | STATE | ZIP

TO **HOSPITALS:** Attach to this form your bill and a completed copy of your own AMA approved form or UB-92 form.

TO **PHYSICIANS** AND **SUPPLIERS:** If your form provides the information requested below, attach a completed copy.

PHYSICIAN OR SUPPLIER INFORMATION

Date of ILLNESS (first symptom), or INJURY (Accident) or PREGNANCY (LMP)	Date Patient first consulted you for this condition	Has patient ever had same or similar symptoms ❑ Yes ❑ No

Provider of care: (Please check)
❑ Attending Physician ❑ Surgeon ❑ Consulting ❑ Hospital

If other than attending, give name of referring physician.

Name and address of facility where services rendered (if other than home/office)

For services related to hospitalization, give hospitalization dates

ADMITTED | DISCHARGED

DIAGNOSES May use ICD9-CM or DSM III codes.

PRIMARY | **SECONDARY**

Date of Service	Place of Service	Procedure Codes (Identify)	Fully describe procedures; types of therapy, or services furnished for each date given indicate whether primary or secondary (if mental therapy indicate length of session.)	Charges	Amount Paid	Balance Due

SIGNATURE OF PROVIDER	DATE	DEGREE	Total Charge	Amount Paid	Balance Due

YOUR PATIENT'S ACCOUNT NUMBER | PROVIDER I.D. NUMBER | PROVIDER'S NAME

ADDRESS | CITY | STATE | ZIP

If the services were rendered by a psychiatric worker, the following certification must be completed by the attending physician:

Therapy performed by ______________________________ was conducted at my direction under my supervision and I have consulted with the Therapist regarding the patient within the last 90 days. Further, I have reviewed and approved the Plan of Treatment and have examined the patient on the date indicated below

NAME OF ATTENDING PHYSICIAN | DATE OF EXAMINATION

ADDRESS OF ATTENDING PHYSICIAN | CITY | STATE | ZIP

ATTENDING PHYSICIAN'S SIGNATURE | PROFESSIONAL STATUS

Place of service codes

1– (IH)	Inpatient Hospital	4–(H)	Patient's Home	7–(NH)	Nursing Home	O–(OL)	Other Location
2–(OH)	Outpatient Hospital	5–	Day Care Facility (Psy)	8–(SNF)	Skilled Nursing Facility	A–(IL)	Independent Laboratory
3-(O)	Doctor's Office	6–	Night Care Facility (PSY)	9–	Ambulance	B–	Other Medical Surgical Facility