



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 codes1- (IH) Inpatient Hospital
2-(OH) Outpatient Hospital
3-(O) Doctor's Office4-(H) Patient's Home
5- Day Care Facility (Psy)
6- Night Care Facility (PSY)7-(NH) Nursing Home
8-(SNF) Skilled Nursing Facility
9- AmbulanceO-(OL) Other Location
A-(IL) Independent Laboratory
B- Other Medical Surgical Facility