Allied Benefit Systems, Inc.
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Chicago, IL 60690
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International Medical Claim Form

Employer Information

Employer Name	Group Number

Employee Information

Employee Name			Birthdate
Social Security Number/UID			
Employee Address	**City**	**State**	**Zip**
Telephone Number			

Patient Information

Patient Name	Gender	Birthdate
Relationship to Employee ☐ Self ☐ Spouse ☐ Child ☐ Other:		
Patient's Address	**City**	**State** / **Zip**
Patient's Telephone Number	**Patient's Email Address**	

Claim Information

Was this claim due to an accident? ☐ Yes ☐ No	If yes, what was the date of the accident?
Where did the accident occur?	Is this claim the result of a work related illness or injury? ☐ Yes ☐ No

Service Information

Provider Name	Type of Provider	Patient Name	Date of Service	Description of Service	Total Charge

Any Additional Details:

Reimbursement Information

Amount of claim in foreign currency $	Currency name
Country Origin	Exchange rate used
Date of Conversion Rate	Amount of expense in U.S. Dollars $

Please attach proof of expense to claim form (receipt, letter, prescription label or box top, billing statement etc.)

Employee Authorization

AUTHORIZATION TO RELEASE INFORMATION: I hereby certify that the foregoing statements are true to the best of my knowledge. I also authorize any hospital, physician, or other persons who have attended me or examined me or any of my dependents, to disclose to Allied Benefit Systems, Inc. and/or my employer any and all information with respect to any illness or injury, medical history, consultation, diagnosis or treatment, and copies of all hospital or medical records. A photo static copy of this authorization shall be considered as effective and valid as the original.

Employee Signature _____ Date _____

Patient Signature _____ Date _____

My signature below certifies that I did receive the medical services or products herein described, and that I did incur the expenses for which I am seeking benefit reimbursement. I understand that benefit payments are subject to and will be based on the General Limitations, Definitions, Eligibility, and all other provisions contained in the written Summary Plan Description.

Employee Signature _____ Date _____

INSTRUCTIONS FOR FILING A INTERNATIONAL MEDICAL CLAIM

COMPLETE EMPLOYEE'S STATEMENT: PLEASE BE SURE TO ANSWER EVERY QUESTION.

All bills must show the following information. Additional data will be requested if needed.

1) Confirmation of employee information
2) Confirmation of the patient information
3) Confirmation if the claim is related to an accident. If so, if the accident is work related.
4) Provider Name and Address
5) Date of Service and reason for the service rendered.
6) Total Charge for Each Service
7) Provide expense amount in both foreign and U.S. currency, nothing the exchange rate used and the date.
   We recommend you use http://www/oanda.com/convert/classic for exchange rates.
8) Sign and date the claim form.

If a claim is for prescription drugs, attach bills to form after completing "Employee's Statement of Claim" section. All bills must show: patient's name; prescription number; date(s) of purchase; and charge.

Mail the claim form and the itemized bill to the address listed on the back of the Employee's ID card.

KEEP A COPY FOR YOUR RECORDS.

IMPORTANT ITEMS TO NOTE:

1) All charges must be submitted within the time frame specified in the summary plan description. Failure to do so will result in the denial of the charges.

2) From time to time, additional information may be requested in order to process a claim. Any additional information, i.e., other insurance payments, completed claim forms, subrogation forms, accident details, police reports, etc., must be submitted when requested. Failure to do so may result in the denial of the claim.

3) ALWAYS retain a copy for your records.

ALLIED

INTERNATIONAL MEDICAL SUPPLEMENTAL CLAIM WORKSHEET

PATIENT NAME _____ PATIENT UNIQUE ID _____

PATIENT NAME	DATE OF SERVICE	PROVIDER NAME	DESCRIBE SERVICE PROVIDED	AMOUNT OF CLAIM IN FOREIGN CURRENCY	EXCHANGE RATE USED	AMOUNT OF EXPENSE IN U.S. DOLLARS