I. Patient Information — 1A. Alpha prefix Identification number	Copy this from your Blue Cross Blue	Copy this from your Blue Cross Blue Shield identification card.	
B. Patient 's name (First, middle initial, last)	1C. Patient 's date of birth	1D. Patient 's sex  Male Female	
E. Name of subscriber (First, middle initial, last)	1F. Subscriber 's date of birth	1G. Patient 's relationship to subscriber	
	MM/DD/YYYY	Self Spouse Child	
IH. Subscriber 's current mailing address (Street, city, state, and country or	ZIP code)	11. Patient's e-mail address	
2. Other Health Insurance — Is the patient covered under other If yes, complete 2A through 2K below.	health insurance, including Medicare A	or B? Yes No	
2A. Name and address of other insuring company			
2B. Type of policy			
		Medicare Par t B: Yes No  Effecti ve date	
Diagnosis — 3A. Describe illness, injury, or symptoms requiring treating.			
	, ·		
BB. Was patient's treatment due to a work-related accident or condition?	Yes No		
BC. Complete for care related to accidental injuries  Date of accident Local	ation: At home Auto Other		

## General Information

- The Blue Cross Blue Shield Global Core International Claim Form is to be used to submit institutional and professional claims for benefits for covered services received outside the United States, Puerto Rico and the U.S. Virgin Islands.
- For other claim types (e.g., dental, prescription drugs), contact your Blue Cross and Blue Shield Company for filing instructions.
- Please complete all fields. If the information requested does not apply to the patient, indicate N/A (Not Applicable).
- Please attach receipts and medical records (test results, x-rays, etc.), if available.
- Please keep photocopies of all documentation for your personal records.

## Itemized Bill Information

Each provider's original itemized bill must be attached and must contain:

- The letterhead indicating the name and address of the person or organization providing the service
- The full name of the patient receiving the service