International Claims:
Delta Health Systems
PO Box 80
Stockton, CA 95201-3080

International Medical Claim Form

Please see the instructions on page two of this form before completing. Please type or print clearly.

PATIENT AND EMPLOYEE INFORMATION

1a. EMPLOYEE HEALTHCARE ID: Please refer to your medical ID card for your HealthCare ID: ☐☐☐-☐☐☐☐☐ D

1b. Employee Name	1c. Employee DOB / /	1d. Employee Address ☐ NEW Address: ______ ______ City, State, Zip: ______
1e. Patient Name	1f. Patient DOB / /	
	1g. Patients Sex ☐ Male ☐ Female	Patients Relation to Employee ☐ self ☐ Spouse ☐ Child ☐ Domestic Partner ☐ Other

2a. OTHER HEALTH INSURANCE COVERAGE: Is patient covered by any other plan? ☐ Yes ☐ No
If yes please complete sections 2b-2h.

2b. Name of insuring company:	2c. Effective Date / /	2d. Termination Date / /	2e. ID Number
2f. Name of Subscriber:	2g. Subscriber DOB / /	2h. Type of Coverage: ☐ Medical ☐ Dental ☐ Vision ☐ Drug	

PROVIDER OR SUPPLIER INFORMATION

3a. Was condition related to accident? ☐ Yes ☐ No If accident related please provide: Date of accident: ______
Location: ☐ At Home ☐ Auto ☐ Other:
Was the patient's treatment due to a work related accident or condition? ☐ Yes ☐ No

3b. Name and address of facility where services were rendered:	3c. For services related to hospitalization: Admit Date: / / Discharge Date: / /

3d. Diagnosis – Describe illness, injury or symptoms requiring treatment

3e Charges – Use a separate line to list each type of service and attach itemized bills for all services. Bills should be in English and American currency, when possible.

A. Date of Service	B. Name and address of provider	C. Type of provider	D. Description of Service	E. Charges

4. I certify the above is complete and correct and I am claiming benefits only for charges incurred by the patient named above. I understand that all services must be paid in full at the time of service and reimbursement will be made to me by Delta Health Systems for eligible charges.

______ Date ______
Signed employee or patient

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DELTA HEALTH SYSTEMS

International Medical Claim Form Instructions

General Information

The Delta Health Systems International Medical Claim Form is to be used to submit institutional and professional claims for covered services received outside of the United States. For filing instructions for other claim types (i.e. dental, prescription drug, etc) please refer to your ID card or contact Delta Health Systems for assistance. If you are calling from outside the United Sates, please call (209) 948-8483.

The international claim form must be completed for each patient in full and accompanied by itemized bills from the provider of service. When possible, please provide bills in English and American currency.

Please be sure to keep photocopies of all bills and supporting documentation for your personal records.

IMPORTANT ITEMS TO REMEMBER:

- Verify that international benefits are covered by reviewing your summary plan document provided by your employer **before leaving the United States.** Benefits may vary while out of the country and are not guaranteed. If you need assistance, please contact Delta Health Systems Customer Service Department.
- Always carry your medical identification card with you.
- In an emergency situation go directly to the nearest doctor or hospital and provide them with a copy of your medical identification card. Emergency Room services and Urgent Care are covered while outside of the U.S.
- Checks issued for eligible reimbursements will be mailed to the participant using a U.S. address only.

International Claim Form Instructions

Please complete all items on the claim form to eliminate any delay with the processing of your claim. If the information requested does not apply to the patient, indicate N/A (Not Applicable). Special care should be taken when completing the following.

2. Other Health Insurance Coverage

Please complete section 2 items a-h if the patient has other insurance coverage. It is especially important to indicate the name and address of the other insurance company and the policy or identification number of that coverage as well as the name and date of birth of the subscriber.

3. Provider or Supplier Information

Please list the invoices, statements or bills that are included on this claim form. Although itemized bills must also be submitted the information you provide will enable us to process the claim timely and accurately. If additional space is needed please use a separate sheet of paper.

3a. Was the condition related to an accident? Please indicate Yes or No and provide any information that you have regarding the party responsible for all charges.
3b. Please provide name and address of the facility where services were provided.
3c. If the patient was hospitalized please provide the admission and discharge date.
3e. Fully describe procedures, medical services or supplies furnished for each date of service provided and explain any unusual services or circumstances. Please attach all invoices, statements or receipts received from the provider of service.
   a. Date of service – inclusive dates may be indicated for bills containing multiple dates of service
   b. Name and address of the provider of services.
   c. Description of service – for example: hospital admission, office visit, x-ray, laboratory tests, surgery, etc.
   d. Charges – bills must be itemized to show a separate charge for each service. If the bill has already been paid please indicate the date it was paid including dollar amount, check number, etc.

4. Signature

The International Medical Claim Form must be signed and dated by the subscriber, spouse or the patient.

Itemized Bill Information

Each provider's original itemized bill must be attached and must contain the following to ensure the processing of your claim(s).

- Name and address of the person or provider performing the service
- Full name of the patient receiving the service
- The date of each service
- A description & charge for each service