St Luke's HEALTH PLAN

International Claim Form

Claim Submission Address:
St. Luke's Health Plan
PO Box 1739
Boise, ID 83702-5809

Customer Service:
833-840-3600
Email: customerservice@slhealthplan.org

1 - MEMBER/ PATIENT

Member Name: (First, Middle, Last)	**Member Number:**	**Group Number:**		
Address: *Is this a New Address?* Y ☐ N ☐	**City:**	**State:**	**Zip Code:**	**Birth Date:**
Patient Name: *(First, Middle, Last)*	**Patient's relationship to member:**			**Sex:**
	Self ☐ Spouse ☐ Child ☐ Disabled Dependent ☐ Other ☐ _____			M ☐ F ☐

Does the patient have other health insurance coverage? Y ☐ N ☐ **If Yes, please complete section 2.**

2 - OTHER INSURANCE

Policyholder's Name: *(First, Middle, Last)*	**Birth Date:**	**Policyholder's Member Number**	**Effective Date:**

Other Insurance carrier's information:

Insurance Name:	**Address:**		
City:	**State:**	**Zip Code:**	**Phone Number:**
			( )

Policyholder's employment status:	**Patient's relationship to member:**
Active ☐ Disabled ☐ Retired ☐ Effective Date: ____/____/_____	Self ☐ Spouse ☐ Child ☐ Other ☐

Type(s) of Coverage: (Check all that apply)

Hospitalization ☐ Medical-surgical ☐ Dental ☐ Vision ☐ Drug ☐ Major medical ☐
Other (Specify) ☐ _____

Coverage Covers: (Check all that apply)

Policyholder only ☐ Policyholder and spouse ☐ Policyholder and child(ren) ☐ Family ☐

Is the patient entitled to benefits under Medicare Part A or B?	Yes ☐ No ☐	If YES, complete the rest of section 2.
Medicare effective date: ____/____/_____	**Medicare ID#:**	
Member's employment status:	Active ☐ Retired ☐ Disabled ☐	

3 - DIAGNOSIS

(A)	**Describe illness, injury, or symptoms requiring treatment and onset date of symptoms or injury.**
(B)	**Was patient's treatment due to work-related accident or condition?** Yes ☐ No ☐
(C)	**Complete for care related to accidental injuries:**
	Date of accident: ____/_____/_____ Location: At Home ☐ Auto ☐ Other ☐ _____
	Time of accident: ____/_____/_____ *If the accident was caused by someone else, attach a statement describing the accident.*

4 - CHARGES

(1A)	**Name and address of provider making charge:**	
	Name:	Address:
(1B)	**Type of provider:**	
(1C)	**Description of service:**	
(1D)	**Date of service or purchase:**	____/_____/_____
(1E)	**Charges:**	
(2A)	**Name and address of provider making charge:**	
	Name:	Address:
(2B)	**Type of provider:**	
(2C)	**Description of service:**	
(2D)	**Date of service or purchase:**	____/_____/_____
(2E)	**Charges:**	
(3A)	**Name and address of provider making charge:**	
	Name:	Address:
(3B)	**Type of provider:**	
(3C)	**Description of service:**	
(3D)	**Date of service or purchase:**	____/_____/_____
(3E)	**Charges:**	
(4A)	**Name and address of provider making charge:**	
	Name:	Address:
(4B)	**Type of provider:**	
(4C)	**Description of service:**	
(4D)	**Date of service or purchase:**	____/_____/_____
(4E)	**Charges:**	

5 - PAYEE	Select one of the following payment options:
	Option A: ☐ Make payment to subscriber; provider has been paid.
	Option B: ☐ Make payment to provider (hospital, doctor), if appropriate. Please complete and sign to authorize direct payment to provider.

General Information

- The St. Luke's Health Plan International Claim Form is to be used to submit claims for benefits for covered services received outside the United States.
- For other claim types (e.g., dental, prescription drugs), contact St. Luke's Health Plan for filing instructions.
- **Please complete all fields in all sections.** 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 with the name and mailing address of the person or organization providing the service.
- The full name of the patient receiving the service (initials are not acceptable).
- Type of provider (for example: hospital, clinic, physical therapist, etc.).
- A description of each service (for example: hospital admission, surgery, office visit, X-ray, laboratory test, etc.).
- The date of each service.
- The charge for each service in U.S. currency.

Other Health Insurance

If the patient holds other insurance coverage, please complete Section 2 as completely as possible. 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 birth date of the person who holds that policy. In addition, if the patient is someone other than the subscriber and has received benefits from any other health insurance plan held by reason of law or employment, the Explanation of Benefits form furnished by the other carrier pertaining to these charges must be included with the claim. A clear photocopy of the other carrier's Explanation of Benefits form is acceptable in place of the original document.

Appeal Rights

If your claim is denied (in whole or in part), you have the right to request an appeal. Please refer to your Plan documents for details on how to file an appeal, applicable time frames, and your rights under federal and state law.

Privacy Notice

St. Luke's Health Plan complies with U.S. privacy regulations, including the Health Insurance Portability and Accountability Act (HIPAA). Please note that health care providers located outside the United States might not be subject to HIPAA or equivalent privacy protections. St. Luke's Health Plan will take reasonable steps to safeguard any personal health information it receives.

Disclaimer

Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and prison confinement.

I certify that the information provided on this claim form is correct and complete, and that I am claiming benefits actually incurred by the named patient. I authorized any hospital, physician, or other provider who participated in the care and treatment of the patient to release all medical or other information requested for the processing of the claim to St. Luke's Health Plan. I hereby agree to reimburse St. Luke's Health Plan in full if this claim is paid incorrectly. Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any material fact thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Member Signature **Date** **(Area Code) Home Phone**

_____ _____ _____