



University System of
Georgia
Guide for **GA TECH**
Employees Residing
Abroad

This guide was designed for employees in the University System of Georgia Indemnity HealthCare plan who reside abroad.

Frequently Asked Questions

1. What program should I use when I reside abroad? *BlueCard Worldwide Program*

2. What is BlueCard Worldwide?

- ✚ BlueCard Worldwide enables BCBS Plan members living abroad to obtain medical assistance and inpatient, outpatient, and professional services from healthcare providers worldwide.
- ✚ The BlueCard Worldwide program applies to institutional and professional services received outside the United States, Puerto Rico, Jamaica, and the U.S. Virgin Islands.

3. What are the benefits of the BlueCard Worldwide Program to members and/or employer groups?

- ✚ Peace of mind for members living overseas
- ✚ A single point of contact for medical assistance services 24 hours a day, 7 days a week, 365 days a year
- ✚ A worldwide network of healthcare providers
- ✚ Access to provider information through BlueCard Access Line from US at 1-800-810-BLUE (2583) or collect at 1-804-673-1177
- ✚ Cashless access to inpatient participating hospitals
- ✚ Centralized administration

4. What is the BlueCard Worldwide Network?

- ✚ The BlueCard Worldwide Network has providers that participate with the program. A sample listing of hospitals are available on the internet at www.bcbs.com (click on “Healthcare Anywhere” then click on “I need healthcare outside of the U.S.”). Members can contact the BlueCard Worldwide Service Center from the US at 1-800-810-BLUE (2563) or from abroad collect at 1-804-673-1177 for any hospital not listed. The member may also call the Service Center for names of physicians that can provide services.

5. How does the member obtain a claim form to file to BlueCard Worldwide?

- ✚ Members can obtain an international claim form by
 - Calling World Access toll free from the US at 1-800-810-BLUE (2583) or from abroad collect at 1-804-673-1177 or
 - Downloading the form at <http://www.bcbs.com/bluecardworldwide/index.html>

6. What if I have a claim for prescription drugs?

- ✚ You would file the claims for prescription drugs to your home plan [BCBSGa, PO Box 7728, Columbus, GA 31908](mailto:BCBSGa@bcbs.com)
- ✚ You would use the regular claim form

7. What are the member's responsibilities related to processing claims through the BlueCard Worldwide Program?

- ✚ BCBSGa members are responsible for:
 - Calling World Access via the BlueCard Access line, from the US 1-800-810-BLUE (2583) or call collect at 1-804-673-1177 from outside the U.S.
 - Notify Worldwide Access if admitted overseas
 - Pay any deductibles, co-insurance or non covered amounts to participation hospitals
 - Pay the provider for outpatient or professional services and submit an international claim form and bills to: BlueCard Worldwide Service Center P.O. Box 72017 Richmond, VA 23255-2017 USA

8. What types of claims does the BlueCard Worldwide program handle? How does the program process claims?

- ✚ The BlueCard Worldwide program processes inpatient and outpatient institutional (facility) and professional claims.
- ✚ For inpatient participating Hospital care: The provider files the claim. The member is not required to pay up front and is only responsible for deductibles, coinsurance, and non covered services. The member is not required to pay up front because World Access will verify eligibility and coverage with the Home Plan and send guarantee of coverage letter to the provider.
- ✚ For outpatient hospital of professional care: The member pays the provider, completes and sends an international claim form to BlueCard Worldwide Service Center.

9. What type of calls does the customer service department of world access service corporation answer? What are their operating hours?

- ✚ The world access customer service center is available 24 hours a day, 7 days a week, 365 days a year. They provide provider physician and hospital information (name, address, phone number) to members. They also provide provider information related to the program. *(Note: For benefit questions you must call your home plan in Georgia @ 1-800-424-8950)*

BlueCard Worldwide[®] International Claim Form



Blue Cross and Blue Shield Plans are independent licensees of the Blue Cross and Blue Shield Association.

Please see the instructions on the reverse side of this form before completing. Please type or print.

Send completed form to: BlueCard Worldwide Service Center
P.O. Box 72017
Richmond, VA 23255-2017 USA

1. Patient Information— 1A. Alpha prefix Identification number *Copy this from your Blue Cross Blue Shield identification card.*

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1B. Patient's name (First, middle initial, last)	1C. Patient's date of birth MM/DD/YYYY / /	1D. Patient's sex <input type="checkbox"/> Male <input type="checkbox"/> Female
1E. Name of subscriber (First, middle initial, last)	1F. Subscriber's date of birth MM/DD/YYYY / /	1G. Patient's relationship to subscriber <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child

1H. Subscriber's current mailing address (Street, city, state, and country or ZIP code)

2. Other Health Insurance— Is the patient covered under other health insurance, including Medicare A or B? Yes No

If yes, complete 2A through 2K below.

2A. Name and address of insuring company

2B. Type of policy <input type="checkbox"/> Family <input type="checkbox"/> Individual	2C. Effective date MM/DD/YYYY / /	2D. Termination date MM/DD/YYYY / /	2E. Policy or identification number of other coverage
2F. Type of coverage Hospital: <input type="checkbox"/> Yes <input type="checkbox"/> No Medical: <input type="checkbox"/> Yes <input type="checkbox"/> No Mental illness: <input type="checkbox"/> Yes <input type="checkbox"/> No	2G. Name of subscriber		2H. Date of birth MM/DD/YYYY / /
2I. Employer of subscriber		2J. Employment status <input type="checkbox"/> Active employee <input type="checkbox"/> Retired employee	
2K. If patient is covered under Medicare, complete the following: Medicare Part A: <input type="checkbox"/> Yes <input type="checkbox"/> No Medicare Part B: <input type="checkbox"/> Yes <input type="checkbox"/> No Effective date _____ Effective date _____			

3. Diagnosis— 3A. Describe illness, injury, or symptoms requiring treatment **3B. Was patient's treatment due to a work-related accident or condition?** Yes No

3C. 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— Use a separate line to list each type of service or provider and attach itemized bills for all services.

4A. Name and address of provider making charge	4B. Type of provider	4C. Description of service	4D. Dates of service or purchase	4E. Charges
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.....
.....

5. Payee— Select one of the following payment options:

5A. Make payment to subscriber; provider has been paid.

1. Currency— Do you want the check issued in the currency reflected on the itemized bill(s) or in U.S. dollars? Currency on itemized bill(s) U.S. dollars

2. Payment Method – Do you want to receive payment via a check or bank wire? Check Provide current telephone number _____

Bank Wire. If you want to receive a bank wire provide the following:

Subscriber name as it appears on bank account: _____ Bank name _____

Bank's Physical Address _____

Account # _____ ABA# _____

5B. Make payment to provider (hospital, doctor). Please complete and sign.

Authorization for Assignment of Benefits

I, the undersigned, authorize and request Blue Cross and Blue Shield to make payment for benefits due herein to:

Name of provider _____ Signature of subscriber or spouse _____ Date _____

6. Signature— I certify the above is complete and correct and that I am claiming benefits only for charges incurred by the patient named above. Authorization is hereby given to any provider of service, that participated in any way in the patient's care, to release to the subscriber's Blue Cross and Blue Shield Plan and its business associates in any country any medical or other personal information that they deem necessary to provide service or adjudicate this claim, recognizing that applicable law concerning personal information may differ among countries. Authorization is also given to the subscriber's Blue Cross and Blue Shield Plan and its business associates in any country to collect, use or release any medical or other personal information that they deem necessary to provide service or adjudicate a claim.

Signature of subscriber or patient _____ Date _____

General Information

The BlueCard Worldwide 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, Jamaica and the U.S. Virgin Islands. For filing instructions for other claim types (e.g., dental, prescription drugs, etc.) contact your Blue Cross and Blue Shield Plan.

The International Claim Form must be completed for each patient in full, and accompanied by fully itemized bills. It is not necessary for you to provide an English translation or convert currency.

Since the claim cannot be returned, please be sure to keep photocopies of all bills and supporting documentation for your personal records.

International Claim Form Instructions

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

2. Other Health Insurance

If the patient holds other insurance coverage, please complete items A through K 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.

4. Charges

Please list here the bills that are being included on this claim. Although itemized bills must also be submitted, your listing will enable us to process the claim more quickly and accurately. If additional space is needed for listing charges, please use a separate sheet of paper to list the following information.

4A. Name and Address of provider— as indicated on the bill. Multiple bills from the same provider may be included on the same line, as long as they are for the same type of service.

4B. Type of provider— for example: hospital, nurse, physician, clinic, physical therapist, etc.

4C. Description of service— for example: hospital admission, office visit, x-ray, laboratory test, surgery, etc.

4D. Date of service or purchase— inclusive dates may be indicated for bills containing multiple dates of service.

4E. Charge— 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.

5. Payee

5A. Make payment to subscriber, designation of currency and payment method — 1) Indicate whether you want to be paid in the currency reflected on the bill(s) or in U.S. dollars and if you want to receive payment via check or bank wire. Please note that not all forms of currency may be available for payment. In the event that you select payment in a currency that is not available, you will be paid in U.S. dollars. Banks will typically charge a flat fee or percentage-based fee to receive a wire. You may want to investigate fees charged by your bank prior to requesting a wire since you will be responsible for any such fees.

2) You must include the following information on this form: your full legal name (initials are not acceptable), your physical address (payments cannot be sent to a P.O. box); for wire payments, the bank's name and physical address (payments cannot be wired to a P.O. box), your account number and your bank's ABA number (the ABA number is a nine digit routing number that identifies a specific financial institution). Also, please provide a copy of a voided check or deposit slip so that the bank information can be validated. For checks to be sent by express mail, you must provide a current telephone number.

5B. Authorization for assignment of benefits— complete item 5B if you prefer that benefits be paid directly to the provider of service.

6. Signature

The International 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 letterhead indicating the name and address of the person or organization providing the service
- The full name of the patient receiving the service
- The date of each service
- A description of each service
- The charge for each service

This completed claim form, together with itemized bills and supporting documentation, should be submitted to:

BlueCard Worldwide Service Center
P.O. Box 72017
Richmond, VA 23255-2017 USA

TIPS

When you need health care outside the U.S., follow these simple steps:

1. Always carry your Blue Cross and Blue Shield identification card.
2. Check with your Blue Cross and Blue Shield Plan before leaving the U.S. because your health care benefits may be different outside the U.S.
3. If you need emergency medical care, go to the nearest hospital. Call the BlueCard Worldwide Service Center collect at 1.804.673.1177 if you're admitted.
4. If you need non-emergency inpatient medical care, you must call the BlueCard Worldwide Service Center. The Service Center will facilitate hospitalization at a BlueCard Worldwide hospital or make an appointment with a doctor. It is important that you call the BlueCard Worldwide Service Center in order to obtain cash-less access for inpatient care. The Service Center is staffed with multilingual representatives and is available 24 hours a day, seven days a week.
5. Call your local Plan for pre-certification or prior authorization, if necessary. Refer to the phone number on the back of your card.

Claims filing and payment information:

- ✚ For inpatient care at a BlueCard Worldwide® hospital that was arranged through the BlueCard Worldwide Service Center, you only pay the provider the usual out-of-pocket expenses (non-covered services, deductible and co-insurance). The provider files the claim for you.
- ✚ For all outpatient and professional medical care, you pay the provider and submit a claim. You may also have to pay the hospital (and submit a claim) for inpatient care obtained from a non-BlueCard Worldwide® hospital or when inpatient care was not arranged through the BlueCard Worldwide Service Center.
- ✚ To submit a medical claim, you complete an International Claim Form and send it to the BlueCard Worldwide Service Center.
- ✚ To submit a pharmacy claim, you complete a regular Claim Form and send it to the address on the back of your card for Blue Cross and Blue Shield of Georgia.

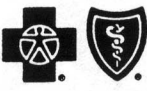
Phone Numbers and Addresses

- ✚ BlueCard Worldwide Service Center:
From US call 1-800-810-BLUE (2563)
From abroad call collect at 1-804-673-1177

- ✚ Blue Cross Blue Shield of Georgia - 1-800-424-8950

- ✚ Claims Address for international medical claims:
PO BOX 72017
Richmond, VA 23255-2017 USA

- ✚ Claims Address for pharmacy claims:
PO BOX 7728
Columbus, GA 31908



HEALTH BENEFITS CLAIM FORM

PLEASE SEE INSTRUCTIONS FOR FILING ON THE REVERSE SIDE. COMPLETE ALL QUESTIONS TO THE BEST OF YOUR ABILITY.

MAIL TO

Blue Cross and Blue Shield of Georgia
P. O. Box 7728
Columbus, Georgia
31908-7728

I PATIENT'S IDENTIFICATION NUMBER		GROUP NUMBER	NUMBER OF ATTACHMENTS
		USGO	

II PATIENT INFORMATION — Person who received services

Name (last, first, MI)		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Relationship to Employee <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	Date of Birth Mo. Day Yr.
Is Patient Enrolled as a Fulltime Student? <input type="checkbox"/> YES <input type="checkbox"/> NO	If "YES", Enter Name of School/College	Location of School/College		Anticipated Date of Graduation

III EMPLOYEE INFORMATION

Name	Address
Daytime Telephone Number	
Home Telephone Number	<input type="checkbox"/> Check here if this is a new address

IV OTHER COVERAGE INFORMATION

Is This Patient Covered By Any Other Group Health Care Plan or Medicare? <input type="checkbox"/> YES <input type="checkbox"/> NO	Was Condition Related To An Automobile Accident? <input type="checkbox"/> YES <input type="checkbox"/> NO		
Was Condition Related To Employment? <input type="checkbox"/> YES <input type="checkbox"/> NO			
IF "YES" to any of the above questions, please complete the following:			
Policyholder's Name	Date of Birth	Policy Number	
Insurance Company's Name	Please indicate type coverage <input type="checkbox"/> Health <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Drug		
Insurance Company's Address	City	State	Zip Code
Employer's Name	Group Number	Medicare Number	Medicare <input type="checkbox"/> Part A <input type="checkbox"/> Part B

V MEDICAL INFORMATION

Is This Condition An Illness <input type="checkbox"/> Injury <input type="checkbox"/> Or Wellness Exam <input type="checkbox"/> ?	Date of Injury Required	Mo. Day Yr.
Describe the illness or injury which required treatment		
How did the injury occur?		

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize the release of any medical information necessary to process this claim and also certify that the above information is correct.)	READ THIS Any intentional false statement in this application or willful misrepresentation relative thereto is a violation of the law.
SIGNED _____	DATE _____

NOTE - Please indicate physician providing service on each physician bill

INSTRUCTIONS FOR COMPLETION OF THE HEALTH BENEFITS CLAIM FORM

We at Blue Cross and Blue Shield of Georgia, Inc. value your membership. The following tips are offered to ensure accurate and timely processing of your claim. If for any reason you should have questions about this form, your claims or benefits, please call our Customer Service department. The telephone number is listed at the bottom of this page.

- I. Your contract number and group number are shown on your Membership card. Please copy the numbers accurately. **Please indicate the number of items you are attaching in the block provided.**
- II. The patient is the person who received the health care services or supplies. Please be sure the patient's name is included on every statement you file, along with the month, day and year of each service provided. **FILE SEPARATE CLAIM FORMS FOR EACH PATIENT.**

Indicate in the additional blocks provided, the patient's sex and relationship to the Employee and the patient's date of birth.

- III. Please furnish the Employee's name, current address and zip code. Please indicate if the address given is a change from the previous address on record.
- IV. If the patient is covered by another group health insurance program or MEDICARE, check "YES" and furnish the name of the Policyholder, the policy number, the insurance company's name and address, the policyholder's employer and the insurance group number. If you are covered by Medicare, please enter your Medicare number and state whether or not you have both Part A and Part B Medicare and the effective date of the Medicare coverage. **If you do not have other coverage, please check "NO".**

If you are covered by another health insurance company or Medicare, you must furnish your Explanation of Benefits or Explanation of Medicare Benefits for the services you are filing on this claim. If you furnish this at the time you file your claim, this will eliminate a delay in the processing of your claim.

- V. Please DESCRIBE THE ILLNESS OR INJURY for which treatment was necessary. In the case of multiple illnesses, please indicate the illness on EACH itemization you are attaching. If the treatment was for an injury, you must provide the date of the injury and how the injury occurred. If this information is not included, your claim could be delayed in an effort to obtain the information.
- VI. The patient (or authorized person) should sign and date the form.

OTHER TIPS FOR FILING A CLAIM

1. Make sure all statements are itemized and include a charge and a description of each service rendered. If the statement reads "lab", we must have the description of the procedure; if an x-ray, we must have the description of the x-ray. You should contact your physician's office for this information. **STATEMENTS STATING "BALANCE DUE" ARE NOT ACCEPTABLE;** you must obtain an itemized statement which is signed by your physician. The **PHYSICIAN'S NAME** must be on all statements. If multiple physicians are listed, please indicate which physician performed the services.
2. Hospital charges must be filed separately.
3. If you are filing charges from a physician who has signed a participating agreement with Blue Cross and Blue Shield of Georgia, Inc., the payment will be sent directly to the physician since the agreement requires the physician to file claims for you. The participating physician has also agreed to accept payment based on the usual, customary and reasonable (UCR) fee allowed before benefit determination is made. You should not be balance billed for charges exceeding the UCR for services rendered when the physician is participating.
4. Please make duplicate copies of all claims for your records.

IF YOU NEED INFORMATION ABOUT COMPLETING THIS FORM OR CLAIMS ASSISTANCE IN GENERAL, PLEASE FEEL FREE TO CALL THE UNIVERSITY SYSTEM OF GEORGIA DEDICATED CUSTOMER SERVICE DEPARTMENT AT:

1-800-424-8950