# HEALTHIER TOGETHER

THE ALLIANCE HEALTH PLAN

Hello International Worker,

We hope this message finds you safe and healthy.

As you are aware, in 2024, we transitioned to a new third-party administrator named Allied Benefit Systems. Allied Benefit Systems is the company we use to process claims, verify eligibility when providers call in, and answer questions regarding claims and coverage for both participants and providers. We recently learned of a glitch with the medical claim form on our website. Once we became aware of this issue, we immediately began working with Allied to resolve it. Our team would like to sincerely apologize for the inconvenience and frustration this may be causing you as part of the reimbursement process. We anticipate the issue on the claim form to be resolved in the next day or two.

**Claim Form Work Around**

1. Print the form.
2. Complete the form.
3. Take a picture of the form with your phone.
4. Email the picture of the form to yourself.
5. Email the form (and receipts above USD 2,000) to allianceclaims@alliedbenefit.com for processing.
    a. Provide basic translation on the receipts.

Please get in touch with the Alliance Benefits Team with any additional questions or concerns. Have a blessed day!

Blessings,

Beth Knight-Pinneo for Alliance Benefits Team

Allied Benefit Systems
PO Box 211651
Eagan, MN 55121
Phone: (800) 288-2078
Fax: (312) 906-8359
AllianceClaims@alliedbenefit.com

# International Medical Claim Form

## Employer Information

| Employer Name | Group Number |
|---|---|
| | |

## Employee Information

| Employee Name | Birthdate |
|---|---|
| | |

**Social Security Number / UID**

| Employee Address | City | State | Zip |
|---|---|---|---|
| | | | |

## Patient Information

| Patient Name | Gender | Birthdate |
|---|---|---|
| | | |

**Relationship to Employee**

☐ Self ☐ Spouse ☐ Child ☐ Other:

## 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

## Provider Information

| Provider Name | TIN | Patient Name | Date of Service | ICD 10 Code | CPT Code | Total Charge |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
| | | | | | | |
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## Reimbursement Information

| | |
|---|---|
| **Amount of currency in foreign currency** | **Currency Name** |
| **Country of Origin** | **Exchange Rate Used** |
| **Date of Conversion Rate** | **Amount of Expense in US 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 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 _____

ASSIGNMENT OF BENEFITS: I hereby authorize payment to the provider of medical services which are otherwise payable to me for services rendered. Payment will be made in accordance with the provisions of the benefit plan.

Employee Signature _____ Date _____

ALLIED

# International Medical Supplemental Claim Worksheet

| **Employee Name** | **Employee UID** |
|---|---|
| | |

| Patient Name | Date of Service | Provider Name | Services Provided | Amount of Claim (Foreign Currency) | Exchange Rate | Amount of Claim (US Currency) |
|---|---|---|---|---|---|---|
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