INSTRUCTIONS FOR FILING AN INTERNATIONAL MEDICAL CLAIM

TO THE EMPLOYEE:

1. Complete all items in the International Medical Claim Form above in full.
2. Sign and date the authorization to release necessary information related to this claim.
3. Attach itemized bills with your receipts for proof of payments (Receipts needed only if over $2,000 USD) The bills must include*:
   - patient's name and information
   - provider's name and address
   - date(s) of service(s)
   - reason for visit and description of services rendered
   - total charge for each service
   - Provide a basic translation on your submitted receipts
4. If information is missing, you may write it directly on the bill, then sign and date your name next to it.
5. Make a copy of your itemized bills for you to keep.
6. Submit the completed claim form together with the itemized bill(s) via online portal or by mail.
   - **To submit online:**
     - Log in to your My Allied Portal via alliedbenefit.com or mobile app
     - Go to the 'Activity' page and select 'Submit Claims'
     - If you have a completed form, click 'Continue'
     - Click 'Add PDF or Image' to upload your claim form and itemized bill via portal, email or by mail
     - To submit by email send claim form to Allianceclaims@alliedbenefit.com
     - Check the box to agree to terms and click 'Submit'
   - **To submit by mail:** Carefully enclose the completed form and itemized bills in a secure envelope. Remit to the mailing address listed on the back of your ID card.
7. **Remember to keep a copy for your records.**

NOTE:

- Incomplete claim forms will be returned to you for missing information. This will delay the processing of the claim. For faster, easier submission of claims, the provider may contact Allied for information regarding electronic claim submissions.
- All claims must be submitted within the time frame specified in your summary plan description. Failure to do so will result in the denial of the charges.
- Additional information or documents may be requested in order to process a claim. Failure to submit requested information in a timely manner may result in the denial of the claim.

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

International Claim Form

Employer Information

Employer Name	Group Number

Employee Information

Employee Name	Birthdate

Member ID/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?	If yes, what was the date of the accident?
☐ Yes ☐ No	
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

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 _____

* TIN, ICD 10 Code and CPT Code only applicable for out of network claims in the US.

**Receipts only needed if expense is over $2,000 USD

International Claim Worksheet (Supplemental)

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)