MHBP aetna®

To allow us to process your Overseas claim promptly, please review the following tips:

1. Please fill out an Overseas Claim Form for each patient and mail them in a separate envelope. (Overseas Military Facilities may submit itemized claims directly to the Plan.) The completed claim form, together with the original itemized bill(s) and any supporting documentation, should be sent to:

   MHBP
   PO Box 981106
   El Paso, TX 79998

2. Always include an itemized bill and/or receipt with the claim. Please keep in mind that by providing as much information as possible in English, you are helping the Plan process your claim.

3. When completing the claim form, please clearly type or print the information. It is important to complete the entire claim form.

4. It is necessary that you tell us why you saw the doctor (medical diagnosis or reason for visit) and the type of doctor you saw (medical doctor, ob/gyn, chiropractor, psychiatrist, etc.).

5. Tell us what country you were in when you had the service(s) and the name of the currency used in that country. Charges should be shown in the foreign currency. (We will calculate the exchange rate based on the date of service.)

6. Precertification is not required for inpatient hospital stays outside of the U.S.

7. DENTAL claims should be submitted on a separate Overseas Claim Form. Please include a tooth (teeth) number when applicable. The plan is unable to return dental X-rays. Please do not submit X-rays unless requested.

8. Please use a Prescription Drug Claim Form for all prescription drugs purchased at pharmacies outside the U.S. and Puerto Rico. There is not a separate “Overseas” Prescription Claim Form. Please do not submit prescription drug claims with your medical or dental claims. Your prescription claims should be submitted on a separate prescription drug claim form and sent to:

   CVS Caremark
   Attn: Claims Department
   PO Box 52196
   Phoenix, AZ 85072-2196

9. It is OK to make photocopies of the claim form.

10. Submit the claim as soon as possible after the expense is incurred. Claims must be submitted no later than December 31st following the year of service. Please keep in mind that all overseas claims, with the exception of services rendered at a U.S. government facility, are paid directly to the Enrollee.

We are available 24 hours a day, 7 days a week (except certain holidays) for your convenience. When you are in the continental U.S., you may contact a Member Services Representative at **1-833-497-2416 (TTY: 711)**. When you are overseas, if the country you intend to call from does not allow toll-free calling, please contact us at **1-480-445-5106 (TTY: 711).**

MHBP aetna

Overseas Medical Claim Form

PO Box 981106
El Paso, TX 79998

Please complete this claim form properly and in its entirety.

To avoid delays in processing, be sure to attach original itemized bill(s) along with any supporting documentation.

Patient Information

Enrollee's ID Number	Relationship to Enrollee		
Patient's Name (Last, First, MI)			
Address			Apt.
City	State	ZIP	
Birth Date (Month/Day/Year)			
Enrollee's Name (Last, First, MI)			
Address			Apt.
City	State	ZIP	
Birth Date (Month/Day/Year)	Enrollee's Email Address	Phone Number	

Other Insurance Information

Is the patient covered under other health insurance? ☐ Yes ☐ No	Policy Number
Policy Holder's Name	Policy Effective Date (Month/Day/Year)
Company Name	Phone Number
Address (Street/City/State/ZIP Code)	

Claim Information

Country where services were rendered	Type of currency listed on original bill
Diagnosis (Describe illness, injury, or symptoms requiring treatment, e.g. cough, sore throat)	
Was patient's treatment related to an accident? ☐ Yes ☐ No If so, date of accident or injury (Month/Day/Year):	
Accident occurred at: ☐ Work ☐ Home ☐ Auto ☐ Other:	

Charges				
Date(s) of service Month/Day/Year	Type of service or procedure	Name of provider making charges	Unit or number of days	Charge (in original currency)

I certify the above is complete and correct and that I am claiming benefits only for the charges incurred by the patient named above. Authorization is hereby given to any provider of service, which participated in any way in the patient's care, to release to the Mail Handlers Benefit Plan, any medical information which they deem necessary to adjudicate this claim.

Signature of Enrollee or Patient	Date

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the service for which the Medicare claim is made. See 42 CFR 411.24(1).The patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured".

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full.
See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered as "incident" to a physician's professional service, **1)** they must be rendered under the physician's immediate personal supervision by his/her employee, **2)** they must be an integral, although incidental part of a covered physician's service, **3)** they must be kinds commonly furnished by physician's offices, and **4)** the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536).For Black Lung claims, I further certify that the services performed were for Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Anyone who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION

(PRIVACY ACT STATEMENT)

We are authorized by HCFA, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872, and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101; 41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties' payors to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, "Carrier Medicare Claims Record", published in the **Federal Register**, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records", **Federal Register**, Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim, with the one exception discussed below; there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the “Computer Matching and Privacy Protection Act of 1988”, permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State’s Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal and State laws.

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing date sources, gathering and maintaining data needed, and completing and reviewing the collection of information.
Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to **HCFA, Office of Financial Management, PO Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (OMB-0938-0008), Washington, D.C. 20503.**

TTY: **711**

English	**To access language services at no cost to you, call the number on your ID card.**
Amharic	የቋንቋ አገልግሎቶችን ያለክፍያ ለማግኘት፣ በመታወቂያዎት ላይ ያለውን ቁጥር ይደውሉ፡፡
Arabic	للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء الصال على الرقم الموجود على بطاقة اشتراكك.
Armenian	Ձեր նախընտրած լեզվով ավվճար խորհրդատվություն ստանալու համար զանգահարեք ձեր բժշկական ապահովագրության քարտի վրա նշված հէրախոսահամարով հէրախոսահամարով
Carolinian (Kapasal Falawasch)	Ngir mëna am sarwis lakk yi te doo fay, woo nimero bi am ci sa kàrt.
Chamorro	Para un hago' i setbision lengguåhi ni dibåtde para hågu, ågang i numiru gi iyo-mu kard aidentifikasion.
Chinese Traditional	如欲使用免費語言服務，請撥打您健康保險卡上所列的電話號碼
Cushitic-Oromo	Tajaajiiloota afaanii gatii bilisaa ati argaachuuf, lakkoofsa fuula waraaqaa eenyummaa (ID) kee irraa jiruun bilbili.
French	Pour accéder gratuitement aux services linguistiques, veuillez composer le numéro indiqué sur votre carte d'assurance santé.
French Creole (Haitian)	Pou ou jwenn sèvis gratis nan lang ou, rele nimewo telefòn ki sou kat idantifikasyon asirans sante ou.
German	Um auf den für Sie kostenlosen Sprachservice auf Deutsch zuzugreifen, rufen Sie die Nummer auf Ihrer ID-Karte an.
Greek	Για πρόσβαση στις υπηρεσίες γλώσσας χωρίς χρέωση, καλέστε τον αριθμό στην κάρτα ασφάλισής σας.
Gujarati	તમારે કોઇ પણ તના ખર્ચ ના ભાષા સેવાઓ મેળવવા માટે, તમારા આઇ કાડપર રહેલ નંબર પર કૉલ કરવો.
Hindi	बना कसी कमत के भाषा सेवाआ का उपयोग करने के लए, अपने आइड काडर् पर दए नंबर पर कॉल कर।
Hmong	Yuav kom tau kev pab txhais lus tsis muaj nqi them rau koj, hu tus naj npawb ntawm koj daim npav ID.
Italian	Per accedere ai servizi linguistici senza alcun costo per lei, chiami il numero sulla tessera identificativa.
Japanese	無料の言語サービスは、IDカードにある番号にお電話ください。
Karen	လၢကမၤန့ၢ် ကျိာ်တၢ်မၤစၢၤတၢ်မၤ လၢတလိာ်လဲာ်ဘူာ်လဲာ်စ့ၤ လၢနဂီၢ်အဂီၢ်, ကိးနီာ်ဂံၢ် လၢအအိဉ် ဖဲန ID အဖီခိဉ်နၥ်တက့ၢ်.
Korean	무료 다국어 서비스를 이용하려면 보험 ID 카드에 수록된 번호로 전화해 주십시오.
Laotian	ເພື່ອເຂົ້າເຖິງບໍລິການພາສາທີ່ບເສຍຄ່າ, ໃຫ້ໂທຫາເບີໂທຢູ່ໃນບັດປະຈຳຕົວຂອງທ່ານ.
Mon-Khmer, Cambodian	ដើម្បីទទួលបនសេវាកម្មភាសាដែលឥតគិតថ្លៃសម្រាប់លោកអ្នក សូមរទូរសព្ទកាន់លេខដែលមាននលើបណ្ណសម្គាល់ខ្លួនរបស់លោកអ្នក។
Navajo	T’áá ni nizaad k’ehjí bee níká a’doowoł doo bą́ą́h ílínígóó naaltsoos bee atah nílį́igo nanitinígíí bee néého’dólzinígíí béésh bee hane’í biká’ígíí áajį’ hólne’.
Pennsylvanian-Dutch	Um Schprooch Services zu griege mitaus Koscht, ruff die Nummer uff dei ID Kaart.
Persian-Farsi	برای دسترسی به خدمات زبان به طور رایگان، با شماره قید شده روی کارت شناسایی خود تماس بگیرید.
Polish	Aby uzyskać dostęp do bezpłatnych usług językowych, należy zadzwonić pod numer podany na karcie identyfikacyjnej.
Portuguese	Para aceder aos serviços linguísticos gratuitamente, ligue para o número indicado no seu cartão de identificação.
Punjabi	ਤੁਹਾਡੇ ਲਈ ਬਿਨਾ ਕਿਸੇ ਕੀਮਤ ਵਾਲੀਆ ਪੰਜਾਬੀ ਸੇਵਾਵਾ ਦੀ ਵਰਤੋ ਕਰਨ ਲਈ, ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ ‘ਤੇ ਦਿੱਤੇ ਨੰਬਰ 'ਤੇ ਫ਼ੋਨ ਕਰੋ।
Russian	Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону, приведенному на вашей идентификационной карте.
Samoan	Mō le mauaina o 'au'aunaga tau gagana e aunoa ma se totogi, vala'au le numera i luga o lau pepa ID.
Serbo-Croatian	Za besplatne prevodilačke usluge pozovite broj naveden na Vašoj identifikacionoj kartici.
Spanish	Para acceder a los servicios lingüísticos sin costo alguno, llame al número que figura en su tarjeta de identificación.
Syriac-Assyrian	ܐܢ ܚܫܒܬܐ ܬܠܘܢ ܓܠ ܝܠܚܕܘܬܐ ܕܫܒܪܬܐ ܟܠܬܼ ܡܚܠܬܐ، ܡܢܡܚܢ ܡܢܐ ܓܠ ܦܬܩܐ ܡܩܛܘܬܐ ܕܢܘܚܢ.
Tagalog	Upang ma-access ang mga serbisyo sa wika nang walang bayad, tawagan ang numero sa iyong ID card.
Thai	หากท่านต้องการเข้าถึงการบริการทางด้านภาษาโดยไม่มีค่าใช้จ่าย โปรดโทรหมายเลขที่แสดงอยู่บนบัตรประจำตัวของท่าน
Ukrainian	Щоб безкоштовнj отримати мовні послуги, задзвоніть за номером, вказаним на вашій ідентифікайній картці.
Vietnamese	Để sử dụng các dịch vụ ngôn ngữ miễn phí, vui lòng gọi số điện thoại ghi trên thẻ ID của quý vị.