# International Claim Form

***Submit Completed form via your member portal or via e-mail to corpclaims@payerfusion.com***

Please see the instructions on the next page of this form before completing. Claims must be complete and submitted within the filing period stated in your policy (check your policy for a list of the documents required).

WellAway
Keeping You Well, While You're Away.®

**Type of Claim** ☐ Medical ☐ Dental ☐ Vision ☐ Pharmacy

## Patient Information

| | |
|---|---|
| Patient's full name: | Patient's gender: ☐ Male ☐ Female |
| Member ID number: | Date of birth (mm/dd/yyyy): |

## Policyholder Information

| | |
|---|---|
| Name of Policyholder: | Date of birth (mm/dd/yyyy): |
| Patient's relationship to Policyholder: ☐ Self ☐ Spouse ☐ Child | Phone number: |
| Full address: | Email: |

## Other Health Insurance

| | |
|---|---|
| Is the patient covered under other health insurance? ☐ Yes ☐ No | Name of other insuring company: |
| Address of other insuring company: | |
| Type of policy: ☐ Family ☐ Individual | Effective date (mm/dd/yyyy): |
| Policy or identification number of other coverage: | Termination date (mm/dd/yyyy): |
| Type of coverage: Medical: ☐ Yes ☐ No Hospital: ☐ Yes ☐ No Mental Illness: ☐ Yes ☐ No | |
| Full name of Policyholder: | Date of birth (mm/dd/yyyy): |
| Employment status: ☐ Active Employee ☐ Retired Employee | Employer of Policyholder: |

## Diagnosis

If the accident was caused by someone else, attach a statement describing the accident.

| | | |
|---|---|---|
| **Describe illness, injury, or symptoms requiring treatment and onset date of symptoms or injurry:** | | |
| **Was patient's treatment due to accident or condition?** ☐ Yes ☐ No | | |
| **Complete for care related to accidental injuries:** | **Date of accident (mm/dd/yyyy):** | **Time of accident:** |
| **Location:** ☐ At Home ☐ Auto ☐ Other: | | |

## Charges – Use a separate line to list each type of service or provider and attach itemized bills for all services.

| | | |
|---|---|---|
| Name and address of provider making charge: | | Type of provider: |
| Description of service: | Dates of service or purchase: | Charges: |

## Payee – Our payments are made electronically. Select one of the following:

☐ Electronic Payment to policyholder

☐ **Make payment to provider (hospital, doctor), if appropriate.** Please complete and sign to authorize direct payment to provider. I, the undersigned, authorize and request payment for benefits due herein to be made to the following provider of services, if such direct payment is deemed appropriate by WellAway Limited.

## Account Information

| | | |
|---|---|---|
| Bank Name: | | |
| Bank Address: | | |
| City: | State: | Postal Code: |
| Account Type: ☐ Checking ☐ Savings | ACH Routing Number *(9 Digit Number):* | Account Number: |

| | | |
|---|---|---|
| Name of provider: | Signature of Policyholder: | Date (mm/dd/yyyy): |

**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 WellAway 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 WellAway 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, adjudicate a claim or as otherwise described in WellAway's Notice of Privacy Practices.

| | |
|---|---|
| Signature: | Date (mm/dd/yyyy): |

Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

## Special care should be taken when completing the following fields:

### Patient Information

**Patient's full name -** For check payments, provide your full name (initials are not acceptable).
**Policyholder's full address -** If check payment is requested, this address will be used. Please provide your physical address (payments cannot be sent to a P.O. Box).

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### Other Health Insurance

If the patient holds other insurance coverage, please complete all of the information requested. 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 policyholder 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.

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### Charges

Please list the attached bills. Although itemized bills from the provider showing a separate charge for each service must be submitted, your listing will enable us to process the claim more quickly. If additional space is needed, please use a separate sheet of paper to list the following information:

**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.
**Type of provider -** for example: hospital, nurse, physician, clinic, physical therapist, etc.
**Description of service -** for example: hospital admission, office visit, x-ray, laboratory test, surgery, etc.
**Date of service -** inclusive dates may be indicated for bills containing multiple dates of service.
**Charge -** as indicated on the bill. If the bill has already been paid, please indicate the date it was paid.

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### 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
- The description of each service
- The charge for each service in local currency
- Proof of payment

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### Payee

**Make payment to policyholder -** Please note that reimbursements are payable in the same currency you have paid your premium. There should be no charge to you for receiving ACH payments. However, you may want to investigate fees charged by your bank prior to requesting an ACH payment, since you will be responsible for any such fees.

Authorization for payment to provider - complete this information if you prefer that benefits be paid directly to the provider of service. Direct payment to the provider is at the discretion of WellAway Limited, except where required by law.

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### Signature

The International Claim Form must be signed by the patient. If patient is under 18 years of age, parent or guardian must sign.

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