



## Participant's Foreign Claim Questionnaire

**Participant:** \_\_\_\_\_ **SSN:** \_\_\_\_\_

**Patient:** \_\_\_\_\_ **DOS:** \_\_\_\_\_

The Plan covers services considered reasonable and necessary in connection with the diagnosis and treatment of any non-industrial illness or injury. The information provided below will assist us in expediting your request.

**1. In what country were the services provided:** \_\_\_\_\_

**2. For what condition did you seek treatment (In your own words, what was your complaint)?:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**3. Had you received treatment for this condition previously?    Yes            No**

If yes, where and when? \_\_\_\_\_

**4. Were you treated at a:      Hospital          Facility          Clinic          Doctor's office**

**5. By a physician?      Yes      No, or other (what credentials did they have?)** \_\_\_\_\_

**6. What was the provider's name?** \_\_\_\_\_

**7. How did you get to the hospital/facility/clinic?** \_\_\_\_\_

**8. Where did you stay while you were receiving treatment? (Hospital/Clinic/Hotel/Friend)**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**9. Please describe the treatment and/or services received:** \_\_\_\_\_

**10. Was the treatment you received explained to you?    Yes            No**

**11. List all items billed:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Patient: \_\_\_\_\_

12. Was the cost of the treatment discussed with you?      Yes      No

13. Did you make any payment for services performed?      Yes      No

If yes, how much (please list all individual payments):

Date	Amount	Date	Amount
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

14. Do you have any receipts reflecting your payment?      Yes      No

If yes, please **attach copies** of all receipts and bills to your completed form.

15. Did the hospital/facility/clinic indicate that this payment was payment in full for all of your treatment?      Yes      No

16. If additional information is required, may we contact you? If yes, please leave a daytime telephone number: \_\_\_\_\_

**I HEREBY DECLARE THAT THE FOREGOING INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF.**

\_\_\_\_\_  
Signed by Participant or Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

Relation to Claimant: \_\_\_\_\_