WEA trust
45 Nob Hill Road | Madison, Wisconsin 53713-3959
800.279.4000 WEAtrust.com

International Claim Form

Please see the instructions on the second page of this form before completing. Please type or print.

Send completed forms to: WEA Trust
ATTN: Claims
PO BOX 211438
Eagan, MN 55121

OR Fax: 608-276-9119

1. Patient Information

1A. Member number	**1B. Group number**
1C. Patient's name (First, middle initial, last)	**1D. Phone number**
1E. Patient's date of birth MM/DD/YYYY / / **1F. Subscriber's date of birth** MM/DD/YYYY	**1G. Patient's sex** ☐ Male ☐ Female
1H. Name of subscriber (First, middle initial, last)	**1I. Patient's relationship to subscriber** ☐ Self ☐ Spouse ☐ Child
1J. Subscriber's current mailing address (Street, city, state, and country or ZIP code)	**1K. Patient's email address**

2. Other Health Insurance

Is the patient covered under other health insurance, including Medicare A or B? ☐ Yes ☐ No

If yes, complete 2A through 2E below.

2A. **Name and address of other insurance company**

2B. **Policy or ID number of other insurance**

2C. **Name of subscriber**

2D. **Subscriber's date of birth** MM/DD/YYYY / /

2E. **If patient is covered under Medicare, complete the following:** Medicare Part A ☐ Yes ☐ No Effective date _____ Medicare Part B ☐ Yes ☐ No Effective date _____

3. Diagnosis

3A. Illness, injury, or symptoms requiring treatment, including onset date.

3B. **Was treatment due to a work-related accident or condition?** ☐ Yes ☐ No

3C. **Complete for accident related injuries**

Date of accident _____ Location: ☐ Home ☐ Auto ☐ Other: ----------

Time of accident _____ *(If accident caused by another person, please attach a description of the accident)*

4. Charges

Please use a separate line for each type of service or provider. Please attach all itemized bills you have received.

4A. **Provider name & address**	4B. **Type of provider**	4C. **Description of services**	4D. **Date of services**	4E. **Charges**

5. Signature

I certify the information contained herein is complete and accurate. I am claiming benefits only for charges incurred for the patient listed above. Authorization is hereby granted to any service provider, that participated in the patient's care, to release to WEA Trust Insurance any medical and personal information WEA Trust Insurance deems necessary to provide service and adjudicate claims reported herein. I realize laws outside of the United States pertaining to my personal information may differ.

Signature of subscriber or patient _____ Date _____

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International Claim Form *(continued)*

General information

- This form is to be used to submit claims for services received outside the United States.
- Please complete all fields. If the information requested does not apply to the patient, please mark the field as N/A.
- **Please attach all legible receipts and medical records translated to English, and proof of payment to allow for prompt processing.**
- Please keep photocopies of all submitted documents for your personal records.

Itemized bill information

Each provider's original itemized bill must be attached and contain:

- Letterhead indicating the name and address of the person or organization providing the service
- Full name of the patient receiving the service
- Date of each service
- Description of each service translated to English
- Charge for each service in US currency
- Claim form if you have one

Please take special care when completing the following:

1. Patient Information: Please fill in all to allow for prompt processing.

2. Other Health Insurance

If the patient holds other insurance coverage, please complete Items A through E as completely as possible. Please indicate the name and address of the other insurance company and the policy or Identification number of that coverage. Also, indicate the name and birth date of the person (subscriber) who holds that policy.

In addition, if the patient is someone other than the subscriber and has received benefits from any other health insurance plan held by reason of law or employment, please attach the Explanation of Benefits furnished by the other carrier pertaining to these charges. A photocopy of the other carrier's Explanation of Benefits is acceptable.

3. Diagnosis and Procedure Code

3A. Diagnosis

3B. Procedure Codes

3C. Workers Compensation

3D. Accident

If you have the ICD10 and CPT Codes, please supply to us.

4. 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, in any way, please use a separate sheet of paper to list the following information:

4A. 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.

4B. Type of provider - for example: hospital, nurse, physician, clinic, physical therapist.

4C. Description of service - for example: hospital admission, office visit, x-ray, laboratory test, hospital inpatient, hospital outpatient.

4D. Date of service or purchase - inclusive dates may be indicated for bills containing multiple dates of service.

4E. Charge - cost of the service in U.S. dollars.

5. Signature

The form must be signed and dated by the subscriber, spouse, or the patient.

Disclosure Statement

Any person who knowingly or willfully presents false or fraudulent claim(s) for payment, or who knowingly or willfully presents false information to obtain insurance and/or insurance payments is guilty of a crime and may be subject to punishment by law.