International Claim Form

You may use the GEHA International Claim Form to submit institutional and professional claims for benefits for services received outside the United States. Please include the Provider's itemized bill(s) with this form.

Name of Subscriber: ________________________________ GEHA ID number: ____________________________

Name of Patient: ___________________________________ Patient's date of birth: _______________________

Were these expenses the result of an accidental injury? ☐ Yes ☐ No

If "Yes," please supply us with the following information: Accident date: ____________ Time of accident: ______________

Nature of accident: ____

Date of service	Provider name and address	Type of provider (hospital, etc.)	Description of service	Rate of exchange	Charge	Diagnosis

Authorization for assignment of benefits — Complete if you prefer that benefits be paid directly to the Provider of service. I, the undersigned, authorize and request GEHA to make payment for benefits due herein to:

Name of Provider: ____

Signature of Subscriber/Patient: ______________________________ Date: _________________________________

GEHA
Foreign Claims Department
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