Traveling to the **Mainland**

An Independent Licensee of the Blue Cross and Blue Shield Association

BEFORE YOUR TRIP

Know who to see in an emergency
Use the first three letters of your subscriber ID on your card (e.g., XLP) to find participating Blue Cross and Blue Shield providers in the state you'll be visiting.

- Call 1 (800) 810-BLUE (2583) toll-free.
- Visit provider.bcbs.com.

Don't forget your HMSA membership card
Make sure you have your current card while traveling.

SEEING A PROVIDER ON YOUR TRIP

Receive emergency, urgent care, follow-up, routine, and elective care while traveling.
However, HMO and QUEST Integration plans will only pay for emergency and urgent care.

Show your HMSA membership card
This will help the provider determine how to submit the claim.

If you see a participating provider:
You'll only have to pay part of the bill and won't need to submit a claim for reimbursement.

If you see a nonparticipating provider:
You'll need to pay in full. Work with the provider to complete the claim form for medical reimbursement on pages 3 and 4. Make sure you get the right information at the time of service – it will help us file your claim.

FILLING A PRESCRIPTION ON YOUR TRIP

Show your HMSA membership card
This will help the pharmacy determine how the bill will be paid.

If you pay in full, you have to submit a claim.
Work with the provider to complete the claim form for drug reimbursement on pages 5 and 6. Make sure you get the right information at the time of service – it will help us file your claim.

QUESTIONS?

To learn more about how your plan works when you're away from home:

- Visit us at one of our HMSA Centers in Honolulu, Pearl City, or Hilo.
- Call the number on the back of your HMSA membership card.
- Go to hmsa.com, click Member Login, and log on to My Account. If you don't have a My Account, click Create an account.
  - For registration instructions, please visit hmsa.com/help-center/hmsas-my-account-for-hmsa-members/

1072-3363 06:15 JR

Traveling to **Another Country**

hmsa®

An Independent Licensee of the Blue Cross and Blue Shield Association

BEFORE YOUR TRIP

Know who to see in an emergency
Use the first three letters of your subscriber ID on your card (e.g., XLP) to find recognized Blue Cross and Blue Shield providers in the country you'll be visiting.

- Call 1 (800) 810-BLUE (2583) toll-free.
- Visit bluecardworldwide.com.

Don't forget your HMSA membership card
Make sure you have your current card while traveling.

SEEING A PROVIDER ON YOUR TRIP

Receive emergency, urgent care, follow-up, routine, and elective care while traveling.
However, HMO and QUEST Integration plans will only pay for emergency and urgent care.

Show your HMSA membership card
This will help the provider determine how the bill will be paid.

If you pay in full, you must submit a claim.
You'll have to pay in full whenever you get services without being admitted into a hospital or skilled nursing facility. Work with the provider to complete the claim form for medical reimbursement on pages 3 and 4. Make sure you get the right information at the time of service – it will help us file your claim. If possible, ask for the information in English and the costs in U.S. dollars.

FILLING A PRESCRIPTION ON YOUR TRIP

Look at your HMSA membership card to see if you have drug coverage.
If you have drug coverage, you will see the word DRUG followed by three digits on the lower right section of your card.

If you need to fill a prescription, you'll have to file a claim.
Work with the provider to complete the claim form for drug reimbursement on pages 5 and 6. Make sure you get the right information at the time of service – it will help us file your claim. If possible, ask for the information in English and the costs in U.S. dollars.

QUESTIONS?

To learn more about how your plan works when you're away from home:

- Visit us at one of our HMSA Centers in Honolulu, Pearl City, or Hilo.
- Call the number on the back of your HMSA membership card.
- Go to hmsa.com, click Member Login, and log on to My Account. If you don't have a My Account, click Create an account.
  - For registration instructions, please visit hmsa.com/help-center/hmsas-my-account-for-hmsa-members/

1072-3363 06:15 JR

Medical Claim Form

If you saw a doctor or specialist (or other provider) who doesn't participate with HMSA or you saw a provider while away from home and you paid for services up front, please submit your claim as follows:

1. Complete both sides of this form.
2. Make copies of your receipts to send with your claim.
3. Mail the completed form and copies of your receipts to:

   HMSA
   Out of State Claims
   P.O. Box 2970
   Honolulu, HI 96802-2970

About the person receiving care

Name: _____

Date of birth: _____ Phone no: _____

About your insurance

Your HMSA subscriber number: _____

Any additional health plan you may have: _____

Please turn the page over and tell us about the services you received. Here's a sample of a completed form.

SAMPLE TEMPLATE

Please describe the service	Examination		
How much it cost	$150		
Country where the service was provided	Australia		
Date(s) of the injury or the start of the illness	10/1/14	**Date(s) of services**	10/1/14
What you sought treatment for	Chest pain		
Where it was performed	■ Office ☐ Clinic ☐ Hospital ☐ Other: _____		
Name of the provider	Dr. Smith		
Provider's address	1234 First Street, Sydney New South Wales, Australia		
Provider's phone number	+612345678		

Please tell us about the services you received.

Please describe the service			
How much it cost			
Country where the service was provided			
Date(s) of the injury or the start of the illness		Date(s) of services	
What you sought treatment for			
Where it was performed	Office Clinic Hospital Other: ____________		
Name of the provider			
Provider's address			
Provider's phone number			

Please describe the service			
How much it cost			
Country where the service was provided			
Date(s) of the injury or the start of the illness		Date(s) of services	
What you sought treatment for			
Where it was performed	Office Clinic Hospital Other: ____________		
Name of the provider			
Provider's address			
Provider's phone number			

Please describe the service			
How much it cost			
Country where the service was provided			
Date(s) of the injury or the start of the illness		Date(s) of services	
What you sought treatment for			
Where it was performed	Office Clinic Hospital Other: ____________		
Name of the provider			
Provider's address			
Provider's phone number			

CVS CAREMARK

14423-1010
STANDARD

Prescription Reimbursement Claim Form

Important!

- Always allow up to 30 days from the time you send this form until the time you receive the response to allow for mail time plus claims processing
- Keep a copy of all documents submitted for your records.
- Do not staple or tape receipts or attachments to this form.
- Reimbursement is not guaranteed and the contractor will review the claims subject to limitations, exclusions and provisions of the plan.

STEP 1 Card Holder/Patient Information

This section must be fully completed to ensure proper reimbursement of your claim.

Card Holder Information

Identification Number *(refer to your prescription card)*

Group No./Group Name

Name *(Last Name)*

(First Name)

(MI)

Address

Address 2

City

State

Zip

Country

Patient Information–Use a separate claim form for each patient.

Name *(Last Name)*

(First Name)

(MI)

Date of Birth

Male

Female

Phone Number

Relationship to Primary member

Member ☐ Spouse ☐ Child ☐ Other _____

Other Insurance Information

COB (Coordination of Benefits)

Are any of these medicines being taken for an on-the-job injury? ❍ Yes ❍ No

Is the medicine covered under any other group insurance? ❍ Yes ❍ No

If yes, is other coverage: ❍ Primary ❍ Secondary

If other coverage is Primary, include the explanation of benefits (EOB) with this form.

Name of Insurance Company_____ ID #_____

Important! A signature is REQUIRED

NOTICE

Any person who knowingly and with intent to defraud, injure, or deceive any insurance company, submits a claim or application containing any materially false, deceptive, incomplete or misleading information pertaining to such claim may be committing a fraudulent insurance act which is a crime and may subject such person to criminal or civil penalties, including fines, denial of benefits, and/or imprisonment.

I certify that I (or my eligible dependent) have received the medicine described herein. I certify that I have read and understood this form, and that all the information entered on this form is true and correct.

x _____

Signature of Member **Date**

(Over)

STEP 2 Submission Requirements:

You MUST include all original "pharmacy" receipts in order for your claim to process. "Cash register" receipts will only be accepted for diabetic supplies. The minimum information that must be included on your pharmacy receipts is listed below:

- Patient Name
- Prescription Number
- Medicine NDC number
- Date of Fill
- Metric Quantity
- Total Charge
- Days Supply for your prescription (you may need to ask your pharmacist for this "Days Supply" information)
- Pharmacy Name and Address or Pharmacy NABP Number

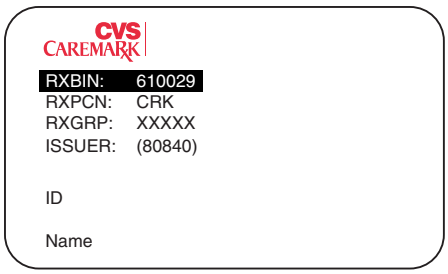
If the Prescribing Physician's NPI (National Provider Identification) number is available, please provide: _____

If this claim is from a foreign country, please fill in below:

Country: _____ **Currency:** _____ **Amount:** _____

Additional Comments

STEP 3 Mailing Instructions:



The RXBIN # is located on front of your CVS Caremark Prescription ID card. Please see highlighted area to the left for reference. Match your RXBIN # to the addresses below.

RXBIN # 610415 mail to:

CVS Caremark
P.O. Box 52116
Phoenix, Arizona 85072-2116

RXBIN # 004336 , 012114 mail to:

CVS Caremark
P.O. Box 52136
Phoenix, Arizona 85072-2136

RXBIN # 610029 mail to:

CVS Caremark
P.O. Box 52196
Phoenix, Arizona 85072-2196

RXBIN # 610474 , 610468 , 004245 or 610449 mail to:

CVS Caremark
P.O. Box 52010
Phoenix, Arizona 85072-2010

RXBIN # 610473 , 610475 mail to:

CVS Caremark
P.O. Box 53992
Phoenix, Arizona 85072-3992

IMPORTANT REMINDER

To avoid having to submit a paper claim form:

- Always have your card available at time of purchase
- Always use pharmacies within your network
- Use medication from your formulary list.
- If problems are encountered at the pharmacy, call the number on the back of your card.