



AFS-USA, Inc. Medical Claim Form

SUBMIT CLAIM FORM TO:

Global Medical Management, Inc. (GMMI)
 7901 SW 36th Street, Suite 100
 Davie, FL 33328
 Phone: (888) 444-7773
 Fax: (954) 370-8130
 e-mail: customerservice@gmmusa.com

PLEASE READ THIS IMPORTANT INFORMATION

- Healthcare providers submitting claims directly to GMMI do not have to complete this form.
- Host family or participant should complete this form if requesting reimbursement for bills already paid by them. If you are given a copy of the industry standard HCFA-1500 or UB-92 Form by the healthcare provider, attach it to this form. If you do so, there is no need to complete the "physician or supplier" section on the back page of this form.
- Reimbursement requests for prescription medications must be accompanied by the original prescription receipt. The prescription receipt is the tag/label that comes attached to the medication containing the student name, doctor/medicine/pharmacy name, date filled, cost, etc.

PARTICIPANT STATEMENT

PARTICIPANT NAME (FIRST) _____

 (LAST) _____
 PARTICIPANT ID# _____ DATE OF BIRTH (MM/DD/YYYY) _____
 PARTICIPANT'S COUNTRY OF ORIGIN _____ PROGRAM START DATE (MONTH/YR.) _____

HOST FAMILY'S NAME _____
 STREET ADDRESS _____
 CITY _____ STATE _____ ZIP _____
 HOST FAMILY'S PHONE NO. (WITH AREA CODE) _____

SERIOUS illness, injury or accident **MUST** be reported to your AFS Regional Service Center immediately by telephone (800-876-2377) with date when accident/illness occurred, name, address and telephone numbers of attending physician and hospital/clinic. Serious cases are motor vehicle accidents, hospitalizations, broken bones, etc. Please consult your HANDBOOK then complete this form and mail to GMMI.

MINOR illness or injury should be described fully on this form and mailed to GMMI on the same day illness or injury occurred.

Is this illness related to any condition existing prior to arrival in the US?

Yes No

PHYSICIAN

NAME _____
 ADDRESS _____
 CITY _____ STATE _____ ZIP _____
 (AREA CODE) TELEPHONE NUMBER _____

HOSPITAL/CLINIC

NAME _____
 ADDRESS _____
 CITY _____ STATE _____ ZIP _____
 (AREA CODE) TELEPHONE NUMBER _____

DATE OF ILLNESS _____ THIS DATE _____ PROVIDER'S TAX ID# _____

ATTENDING PHYSICIAN (IF DIFFERENT FROM ABOVE) _____ (AREA CODE) TELEPHONE NUMBER _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

PAYMENT OF MEDICAL BILL

Is the participant covered by a school or other insurance? Yes No (If yes, give name and address)

INSURANCE NAME _____ (AREA CODE) TELEPHONE NUMBER _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

PLEASE CHECK: No bill expected Bill (s) will be forwarded Bill(s) enclosed and should be paid directly
 Paid bills with cancelled check(s) and/or receipt enclosed

PERSON TO BE REIMBURSED - All reimbursement checks payable to participants are issued in US currency and made out to the participant's name c/o U.S. host family address.

PARTICIPANT NAME _____
 ADDRESS _____
 CITY _____ STATE _____ ZIP _____
 (AREA CODE) TELEPHONE _____

I certify that the preceding statements and answers, and the attached bills and/or statements are true and complete to the best of my knowledge. I authorize the release of information and medical records to Global Medical Management Inc. containing the diagnosis and treatment provided to me. I understand that this information will be held confidential.

Signature _____ Date (mm/dd/yyyy) _____

(OVER)

| | | | |
|---|------------------|------------------|-----|
| ACCIDENT (complete only if claim is due to accident) In the event of a car accident provide a police report. | DATE OF ACCIDENT | TIME OF ACCIDENT | |
| HOW DID THE ACCIDENT HAPPEN? | | | |
| WHERE DID THE ACCIDENT HAPPEN? | | | |
| NAME OF INSURANCE OF OTHER PARTIES INVOLVED | | | |
| ADDRESS OF INSURANCE OF OTHER PARTIES INVOLVED | CITY | STATE | ZIP |

TO HOSPITALS: Attach to this form your bill and a completed copy of your own AMA approved form or UB-92 form.

PHYSICIANS AND SUPPLIERS: If your form provides the information requested below, attach a completed copy.

| PHYSICIAN OR SUPPLIER INFORMATION | | | | | | |
|---|------------------|----------------------------|--|---|---|-------------|
| Date of ILLNESS (first symptom), or INJURY (Accident) or PREGNANCY (LMP) | | | Date patient first consulted you for this condition | | Has patient ever had same or similar symptoms <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Please check: <input type="checkbox"/> Attending Physician <input type="checkbox"/> Surgeon <input type="checkbox"/> Consulting <input type="checkbox"/> Hospital | | | | | | |
| Name and address of facility where services rendered (if other than home/office) | | | | If other than attending, please give name of referring physician. | | |
| For services related to hospitalization, give hospitalization dates. | | | DISCHARGED | | | |
| DIAGNOSES May use ICD9-CM or DSM III codes. PRIMARY SECONDARY | | | | | | |
| Date of Service | Place of Service | Procedure Codes (Identify) | Full describe procedures: types of therapy, or services furnished for each date given, indicate whether primary or secondary (if mental therapy indicate length of session). | Charges | Amount Paid | Balance Due |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| SIGNATURE OF PROVIDER | | | DATE | DEGREE | Total Charge | Amount Paid |
| YOUR PATIENT'S ACCOUNT NUMBER | | | PROVIDER I.D. NUMBER | | PROVIDER'S NAME | |
| ADDRESS | | | CITY | STATE | ZIP | |

| | | | |
|---|--|---------------------|----------------|
| If the services were rendered by a psychiatric worker, the following certification must be completed by the attending physician: | | | |
| Therapy performed by _____ was conducted at my direction under my supervision and I have consulted with the Therapist regarding the patient within the last 90 days. Further, I have reviewed and approved the Plan of Treatment and have examined the patient on the date indicated below: | | | |
| NAME OF ATTENDING PHYSICIAN | | DATE OF EXAMINATION | |
| ADDRESS OF ATTENDING PHYSICIAN | | CITY | STATE ZIP |
| ATTENDING PHYSICIAN'S SIGNATURE | | PROFESSIONAL STATUS | |

Place of service codes:

- | | | | |
|---------------------------------|--------------------------------------|-------------------------------------|--|
| 1 - (H) Inpatient Hospital | 4 - (H) Patient's Home | 7 - (NH) Nursing Home | O - (OL) Other Location |
| 2 - (OH) Outpatient Hospital | 5 - Day Care Facility (Psy) | 8 - (SNF) Skill Nursing Facility | A - (IL) Independent Laboratory |
| 3 - (O) Doctor's Office | 6 - Night Care Facility (Psy) | 9 - Ambulance | B - Other Medical Surgical Facility |