AFS-USA, Inc.
Medical Claim Form

SUBMIT CLAIM FORM TO:

Global Medical Management, Inc. (GMMI)
1300 Concord Terrace, Suite 300
Sunrise, FL 33323
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 ☐ Yes ☐ No
Please check: ☐ Attending Physician ☐ Surgeon ☐ Consulting ☐ Hospital	If other than attending, please give name of referring physician.	
Name and address of facility where services rendered (if other than home/office)	For services related to hospitalization, give hospitalization dates. ADMITTED	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	Balance Due

YOUR PATIENT'S ACCOUNT NUMBER	PROVIDER I.D. NUMBER	PROVIDER'S NAME	
ADDRESS	CITY	STATE	ZIP

If the services were rendered b 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