WellFirst Health®
provided by SSM Health Plan

FOREIGN CLAIM
Submission Form

Instructions

1. One form per date of service/date of occurrence.
2. Fill out the form completely – items left blank may prevent or delay the timely processing of your claim.
3. **Include a receipt for all services** – services listed on the form, but for which there is no receipt, will result in a denial of the claim.
4. Ensure there is an English translation of any receipts or information on this form that is in a language other than English.

Member ID	Member's Last Name	Member's First Name
Date of Occurrence	Country	Foreign Currency
Reason for Treatment Abroad (i.e. what illness/injury occurred)		
Location Services Received (e.g. emergency visit @ St. Mary's Hospital)		
Type of Service(s) Received (i.e. x-ray of right leg, etc.)		
Medical Charges		
Pharmacy Charges		
Total Amount Billed in Foreign Currency:	Total Amount Billed in US Dollars (amount you are requesting for claims payment)	

Mail completed form **with receipts** to: WellFirst Health—Provided by SSM Health Plan
PO Box 56099 | Madison, WI 53705 or
Fax completed form **with receipts** to: ATTN: Claims 608-827-4212