powered by:
SANFORD HEALTH PLAN
(888) 278-6485 TTY: (888) 279-1549

International Medical Claim Form

Member instructions: Please complete and sign the International Claim form.

Submission of this claim form does not guarantee payment of services. Claims may be delayed for missing information.

Submit completed form, along with applicable receipts, itemized statements, and proof of payment to:

By Mail: **Sanford Health Plan**
Attn: Government Programs
PO Box 91110
Sioux Falls, SD 57109-1110

By FAX: Submit your claim with attached receipts or itemized statements and proof of payment to **(605) 312-8237**

SECTION 1

PATIENT INFORMATION			
Patient's Name:			Telephone:
Mailing Address - *Note this will be used for reimbursement by check to Patient.*			
City:		State:	Zip Code:
Patient's DOB:	Gender: ☐ M ☐ F	Patient Align Identification Number:	
If being completed by an Authorized Person on behalf of the Patient, complete this section:			
Authorized Person Full Name			Telephone:
Relationship to Patient:			

Continued on back:

SECTION 2

CLAIM INFORMATION

Date of Service: From: MM	DD	YY	To: MM	DD	YY	Physician, clinic, hospital, pharmacy name and address. *If name and address are on receipts, write "see receipts"*	Procedures; Name of Medication; Medical equipment; If hospital state if inpatient or outpatient	Reason for Visit/ Diagnosis	Country of Claim	Currency of Claim	Total Charges

For services related to an accidental injury complete this section.

Were your injuries caused by an accident? ☐ Yes ☐ No

- If yes is this Motor Vehicle Related? ☐ Yes ☐ No Accident Date _____ Time_____ AM or PM
- If yes, were your injuries Work Related? ☐ Yes ☐ No Accident Date _____ Time_____ AM or PM

Declaration & Signature (Must be Completed)

☐ I authorize the release of any medical or other information necessary to process this claim.
☐ I declare that, to the best of my knowledge, all the information provided with and on this claim form is truthful and correct.

_____ _____

Patient or Authorized Person's Signature | Date Signed