General Board of Global Ministries

StirlingBenefits™ Evolving the Business of Benefits™

Active Missionary Health Plan Claim Form: Medical / Dental/ Vision/ International Rx

Please see the instructions on the second page of this form before completing.
Please limit one form per patient. Send completed form and receipts to:

Stirling Benefits, Inc.
GBGM Claims
20 Armory Lane
Milford, CT 06460

or

Fax: (203) 876-1465
Email: claims@stirlingbenefits.com

Subscribers name: _____
The Subscriber is the person named on the ID card

Subscriber Identification number _____
9-digit number on the front of the ID card

Patient's name

Patient's date of birth
MM/DD/YYYY | | | |

Patient's Gender
☐ Male ☐ Female

Patient's relationship to subscriber (i.e. self, spouse, child)

Patient's e-mail address

Patient's current mailing address (street, city, state, and country or ZIP code)

Diagnosis — Describe illness, injury, or symptoms requiring treatment and onset date of symptoms or injury.

If you received medical care due to an accident, please complete this section

Date of Accident _____ Location: ☐ At home ☐ Auto ☐ Other _____

Time of Accident

If the accident was caused by someone else, attach a statement describing the accident.

Charges — Use a separate line to list each type of service or provider and attach itemized bills for all services.

#	Name and type of provider	Description of service or prescription drug name, including the dosage & dispensing amount	Dates of service or prescription date	Amount in local currency	Exchange rate per US$	Amount in US$
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						

Payee — Select one of the following payment options:

- ☐ **Make payment to General Board of Global Ministries to repay a medical advance**
- ☐ **Make payment to directly to the provider (hospital, doctor), if appropriate**
- ☐ **Make payment to employee/subscriber named on health benefit card**

Any claim found to contain false information and/or documentation may constitute grounds for immediate termination of employment or further legal action.

Signature — I certify the above is complete and correct and that I am claiming benefits only for charges incurred by the patient named above. Authorization is hereby given to any provider of service, that participated in any way in the patient's care, to release to the subscriber's Health Benefits Plan and its business associates in any country any medical or other personal information that they deem necessary to provide service or adjudicate this claim, recognizing that applicable law concerning personal information may differ among countries.

Signature of subscriber, or patient (18 yrs or older) _____ **Date:** _____

General Information

This claim form is to be used to submit institutional and professional health benefits claims for covered services.
Attach your original receipts and number each receipt to match the line number on the claim form.
Please complete one claim form per family member. We also recommend using separate claim forms for medical, prescription, dental and eyeglasses/contact lens expenses.
Please note that missing, illegible and/or non-English information and/or receipts will delay your reimbursement.

Three (3) options for submitting claims:

1. **Mail the form with your receipts to: GBGM Claims, Stirling Benefits, Inc. 20 Armory Lane, Milford CT 06460-3361 USA**
2. **Email the form and receipts to: claims@stirlingbenefits.com (Please try to incorporate the claim form and related receipts into one(1) multiple page PDF or WORD document.**
3. **Fax the form and receipts to; (203) 876-1465**

Keep photocopies of all documentation for your personal records

Medical Advance Claims – Medical Advance documentation should be submitted through the Wellness Program either electronically or by mail.

Email: wellness@umcmission.org or FAX (855) 831-6275 or Mail the form with your receipts to:

Carla J. Warnock, Missionary Health Ministry Wellness Program, 2133 Upton Drive, Suite 126-422, Virginia Beach, VA 23454

Itemized Bill Information

Each provider's original itemized bill must attached and MUST contain:

- The letterhead indicating the name and address of the person or organization providing the service.
- The full name of the patient receiving the service
    - For prescription receipts, the patient's name on the prescription will be accepted in lieu of the patient's name on the receipt.
- The date of service(s)
- The description of each service – for example: hospital admission, office visit, x-ray, etc.
- The charge for each service in local currency
- Provider's signature
- The Diagnosis (nature of illness)

Each prescription submission should include:

- The letterhead or pharmacy store receipt indicating the name and address of the pharmacy or clinic providing the service.
- The prescription drug name.
- Dosage (i.e. strength of medication. This is generally stated in milligram(mg) or milliliters(ml).
- Dispensing Amount – how many tablets or, if liquid, how much.
- Name of prescribing physician – if filled at a clinic rather than an official licensed pharmacy.

***Please note: A drug or medicine that can legally be purchased without a prescription (as in most vitamins, aspirins, cough medicine, etc.) will NOT be covered under this plan.**

Charges

Please list the attached bills. Although itemized bills from the provider showing as separate charge for each service must be submitted, your listing will enable us to process the claim more quickly. If additional space is needed, please use a separate sheet of paper to list the following information:

- Name and type of provider – as indicated on the bill. List one provider per line.
- Description of service – For example: hospital admission, office visit, x-ray, laboratory test, surgery, etc.
- Date of service or prescription – Inclusive dates may be indicated for bills containing multiple dates of service.

Calculating Currency Exchange

Stirling Benefits, Inc uses OANDA Historical, an online currency converter by date – midpoint (http://www.oanda.com/currency/converter) If, however, you are able to provide a bank or credit card statement to confirm the exchange rate, the rate contained in the statement would override the rate quoted by OANDA and Stirling will use the rate you provide to process the claim.

Signature

The claim form must be signed and dated by the subscriber or the patient (if the patient is 18 years or older).

Disclosure Statement

Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines, confinement in prison and termination of employment.