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# INTERNATIONAL MEDICAL CLAIM FORM

**AVOID DELAY —  
ANSWER ALL QUESTIONS**

**PLEASE USE A SEPARATE CLAIM FORM FOR EACH RECEIPT.  
REMEMBER, THE MORE INFORMATION YOU GIVE, THE MORE QUICKLY YOUR CLAIM WILL BE PROCESSED.**

PARTICIPANT NAME:	PARTICIPANT SOCIAL SECURITY NUMBER:
PATIENT NAME:	PHYSICIAN NAME (PROVIDER OF SERVICE)
DATE OF SERVICE:	COST OF SERVICE (CONVERT TO U.S. DOLLARS):

SICKNESS OR INJURY:


SERVICES PERFORMED:


HOME TELEPHONE NUMBER:	WORK TELEPHONE NUMBER:	<p style="text-align: center;"><b>PLEASE SIGN BELOW</b></p> <p>I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND COMPLETE. I AUTHORIZE DESERET HEALTHCARE, HEALTH CARE PROVIDERS, AND/OR PERSONS OR ENTITIES RETAINED BY DESERET HEALTHCARE FOR THE PURPOSE OF AUDITING CLAIMS TO SECURE OR RELEASE INFORMATION RELATING TO THIS CLAIM. I UNDERSTAND, AGREE, AND CONSENT THAT THIS AUTHORIZATION SHALL REMAIN IN EFFECT INDEFINITELY.</p> <p style="text-align: center;">_____</p> <p style="text-align: center;">SIGNATURE <span style="float: right;">DATE</span></p>
E-MAIL ADDRESS:	FAX NUMBER:	

