DMBA

INTERNATIONAL MEDICAL AND DENTAL CLAIM FORM

THE MORE INFORMATION YOU GIVE, THE MORE QUICKLY YOUR CLAIM WILL BE PROCESSED

PARTICIPANT INFORMATION

Participant name: _____ Birth date (MM/DD/YY): _____

DMBA ID number: _____

Address: _____

Home phone: _____ Email: _____

Patient name: _____ Birth date (MM/DD/YY): _____

Patient relationship to participant: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

SERVICE PERFORMED

Country where services were performed: _____ Currency type: _____

Total cost of services (in currency used to pay for services): _____

Condition being treated: _____

SERVICE DATE	PATIENT NAME	SERVICE DESCRIPTION	PROVIDER NAME	SERVICE: MEDICAL OR DENTAL?	COST (IN CURRENCY PAID)

AUTHORIZATION

I certify the above information is true and complete. I authorize DMBA, healthcare providers, and/or persons or entities retained by DMBA 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.

Signature: _____ Date (MM/DD/YY): _____

HELP US PROCESS YOUR CLAIM

1. You must include a properly completed and signed claim form each time you submit a bill.
2. Attach an itemized bill or receipt.
3. Claims **must be submitted within 12 months** from the date the service was rendered. Claims received after this date will not be eligible for benefits.
4. Send the claim form and itemized bills or receipts to:

   DMBA

   P.O. Box 45530

   Salt Lake City, UT 84145

When the claim has been processed, you will receive an *Explanation of Benefits* (EOB) from DMBA explaining how your claim has been handled. If you have any questions, please call DMBA 1-801-578-5600 or toll free at 1-800-777-3622.

NOTE: Be sure to complete all of the requested information. If you don't, processing of your claim may be delayed.