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Department of Veterans Affairs — Foreign Medical Program (FMP) Claim Cover Sheet

Foreign Medical Program
PO Box 469061, Denver, CO 80246-9061 USA
Telephone number: 1-303-331-7590 | Fax number: 1-303-331-7803 | Email: hac.fmp@va.gov
Website: https://www.va.gov/communitycare/programs/veterans/fmp/

Instructions:

Using this form: Use this form to obtain reimbursement for medical services outside the United States. Attach itemized invoices or receipts.

Payments: Payment is based on the exchange rate on the date service was rendered.

Other Health Insurance (OHI): If other health insurance exists, attach the Explanation of Benefits (EOB) from the other health insurance company and an itemized billing statement. Dates of service and provider charges on the EOB must match billing statements.

Translation service: We will translate your claim.

Timely filing requirement: Claims must be received no later than two years from the date of service, or in case of inpatient care, within two years from the date of discharge.

Section I - Veteran Information (Please Print)

Veteran Last Name	Veteran First Name	MI

Social Security Number	VA Claim File Number	Date of Birth *(MM/DD/YYYY)*

Physical Address *(Residence)*	Mailing Address
Country	Country
Telephone Number	Email Address

Section II - Diagnosis or Nature of Illness or Injury

All claim forms must be accompanied by the provider's itemized billing statement(s) which must include the following information:

Provider Information:
1.) Full name and medical title
2.) Office address
3.) Office telephone number
4.) Billing address if different from office address

Claim Information - Diagnoses treated:
1.) Narrative description of each service and/or drug
2.) Each service's billed charge
3.) Date(s) of service

Section III - Claimant Certification

Federal law provides criminal penalties, including a fine and/or imprisonment, for any materially false, fictitious, or fraudulent statement or representation (See 18 U.S.C. 287 and 1001).

Veteran Signature *(Required) (Sign in ink)*	Date *(Required) (MM/DD/YYYY)*

I certify that the above information and attachments are correct and represent actual services, dates, and fees charged.

Attach a receipt of payment for each itemized billing statement (s) to process reimbursement and send payment to the Veteran or Provider.

Payment to be sent to? *(check one box)* ☐ **Veteran** ☐ **Provider**

Privacy Act and Paperwork Reduction Act Information: The information requested on this form is solicited under the **Authority:** Title 38, U.S.C. 1724. The Systems of Records that apply are 23VA10NB3, Non-VA Care (Fee) Records-VA (FR 80 No.146 July 30, 2015) and 54VA10NB3, (FR 80 No. 41, Mar 3, 2015) "Veterans and Beneficiaries Purchased Care Community Health Care Claims, Correspondence, Eligibility, Inquiry and Payment Files --VA". **Purpose:** Records may be used to establish, determine, and monitor eligibility to receive VA benefits and for authorizing and paying Non-VA healthcare services furnished to veterans and beneficiaries and to process claims for medical care and services, and to process stipends. **Principle:** Veterans, Beneficiaries, Pensioned members of the allied forces and Healthcare providers treating individuals who receive care under 38 U.S.C. Chapters 1 and 17. **Routine Use:** Routine use disclosures are in accordance with the Privacy Act of 1974 (as amended) and the applicable system of records notice. **Disclosure:** Your disclosure of the information requested on this form is voluntary. However, if the information including Social Security number (SSN) (the SSN will be used to locate records) is not furnished completely and accurately, Department of Veterans Affairs will be unable to comply with the request. Not supplying the SSN may delay processing your claims. VA may disclose the information as a routine use disclosure outlined in applicable Privacy Act Systems of Records Notice.

The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the Paperwork Reduction Act of 1995. We may not conduct or sponsor and you are not required to respond to, a collection of information unless it displays a valid OMB number. We anticipate that the time expended by all individuals who must complete this form will average 11 minutes. This includes the time it will take to read instructions, gather the necessary facts and fill out the form.