

 **Department of Veterans Affairs CLAIM COVER SHEET – FOREIGN MEDICAL PROGRAM (FMP)**

**VA Health Administration Center  
 Foreign Medical Program, PO Box 469061, Denver, CO 80246-9061 USA**

**Telephone number: 1-303-331-7590**

**Fax number: 1-303-331-7803**

**Email address: hac.fmp@va.gov**

**Website address: www.va.gov/hac**

**INSTRUCTIONS:**

**Using this form:** Use this form to obtain reimbursement for medical services outside the United States (except the Philippines). 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**

Veteran Name *(Last Name, First Name, Middle Initial)* *(mandatory)*

VA Claim #



Social Security # *(mandatory)*

Date of Birth *(mm/dd/yyyy)*



Mailing Address

Telephone Number *(include all prefixes international - country - city)*



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 basic information:

**Provider Information**

Full name and medical title  
 Office address  
 Office telephone number  
 Billing address if different from office address

**Claim Information**

Diagnoses treated  
 A narrative description of each service  
 Each service's billed charge  
 The date(s) of service

PAYMENT TO BE SENT TO? (check one)    VETERAN    PROVIDER

*(retain this portion for your records)*

**Claim Cover Sheet for Foreign Medical Program (FMP)**

**Appendix**

**Privacy Act and Paperwork Reduction Act Information:** The information requested on this form is solicited under Title 38, U.S.C. The authority for collection of the requested information is 38 U.S.C. 1724. The form is used to process each claim for foreign medical services submitted by the veteran for payment. 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. VA may disclose the information as a routine use disclosure outlined in the Privacy Act systems of records notices identified as 54VA16 "Health Administration Center Civilian Health and Medical Program Records - VA" and in accordance with the VHA Notice of Privacy Practices, or as permitted by law. You do not have to provide the requested information but if any or all of the requested information is not provided, it may delay or result in denial of your request for FMP benefits. Failure to furnish the information will not have any effect on any other benefits to which you may be entitled. If you provide VA your Social Security Number, VA will use it to administer your VA benefits. VA may also use this information to identify veterans and persons claiming or receiving VA benefits and their records, and for other purposes authorized or required by law. 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.