OMB Control Number 2900-0648
Estimated Burden Avg: 11 minutes
Expiration Date: 03/31/2027

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**