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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
Surname	Veteran		В
Social Security Number	VA Claim File Number Date of Birth (MM/DD/YYYY)		YYYY)
222554444	123456789 123456789		
Physical Address (Residence)	Mailing Address		
1 Physical Ln	1 Mail Ln		
Place, AL	Place, PA		
12345	12345		
Country USA	Country _{USA}		
Telephone Number	Email Address		
9876543213	veteran@mail.com		
Section II - Diagnosis or Nature of Illness or Injury	Section III - Claimant Certification		
All claim forms must be accompanied by the provider's itemized billing statement(s) which must include the following information:	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).		
Provider Information: 1.) Full name and medical title	Veteran Signature (Required) (Sign	in ink) Date (Required (MM/DD/YYYY)	
2.) Office address3.) Office telephone number4.) Billing address if different from office address	Veteran B Surname	01/01/2024	
Claim Information - Diagnoses treated: 1.) Narrative description of each service and/or drug 2.) Each service's billed charge 3.) Date(s) of service	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)		

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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.

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