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 (FMP)
PO Box 200, Spring City, PA 19475
Telephone number: 1-833-930-0816 | 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 a claim has been submitted to OHI, please 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.

Direct Deposit Reimbursements:

If you receive care under the Foreign Medical Program (FMP), VA has changed how you get reimbursed for your approved service-connected health care claims. Veterans with U.S. bank accounts on file with VA for benefit payments can now receive their FMP reimbursements by direct deposit.

If you are a Veteran already receiving benefit payments, you can confirm or change your domestic bank account information by visiting VA.gov. If you are new to VA, visit VA.gov to create a free Login.gov or ID.me account to manage your bank account information online.

SECTION I - VETERAN INFORMATION *(Please Print)*

VETERAN LAST NAME	VETERAN FIRST NAME	MI

SOCIAL SECURITY NUMBER *(999-99-9999)*	VA CLAIM FILE NUMBER	DATE OF BIRTH *(MM/DD/YYYY)*

PHYSICAL ADDRESS *(Residence)*	MAILING ADDRESS
COUNTRY	COUNTRY
TELEPHONE NUMBER *((999) 999-9999)*	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 - Diagnosis treated:
1.) Narrative description of each service and/or drug
2.) Each service's billed change
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)*	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 STATEMENT: 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.

VA BURDEN STATEMENT: An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 2900-0648, and it expires 03/31/2027. Public reporting burden for this collection of information is estimated to average 11 minutes per respondent, per year, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to VA Reports Clearance Officer at vapra@va.gov. Please refer to OMB Control No. 2900-0648 in any correspondence. Do not send your completed VA Form 10-7959f-2 to this email address.