USA MEDICAL SERVICES
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Claim Form

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Policyholder information

❶ POLICYHOLDER INFORMATION

Full name (Last / First / Middle initial)	DOB (Month / Day / Year)	Policy number

Address:	E-mail address:

Home phone:	Cell phone:	Work phone:	Fax:

❷ PATIENT INFORMATION

Full name (Last / First / Middle initial)	DOB (Month / Day / Year)	Gender M ❍ F ❍

Relation to policyholder Self ❍ Spouse ❍ Child ❍

❸ CLAIM AGAINST OTHER INSURANCE COMPANY

In connection with this diagnosis, illness, or accident, have you made a claim, or are you making a claim, against any other insurance company or benefit plan? YES ❍ NO ❍

Name of company:	Policy number:

❹ PREFERRED METHOD OF REIMBURSEMENT (Please ✓)

❍ Please send a check

❍ Please transfer the reimbursement to my bank account in the USA

❍ Please transfer the reimbursement to my bank account outside the USA

❺ BANK ACCOUNT INFORMATION

Name of beneficiary bank:

Branch number and address:

ABA number for ACH transfers (for US banks only):	SWIFT code (for banks outside the USA):
Account number:	Account holder:
Sub account or final account (if any):	

INTERMEDIARY BANK (please complete for transfers to beneficiary banks outside the USA)

Name of bank:

Address:

ABA number (for US banks only) or SWIFT code:

Account number:

Diagnosis, treatment and charges

❻ DETAILS OF DIAGNOSIS, ILLNESS, OR ACCIDENT

Is this claim resulting from an accident? YES ❍ NO ❍

If Yes, was the injury caused by the act or omission of a person other than the patient? YES ❍ NO ❍

Place of accident Auto ❍ Home ❍ Work ❍ Other ❍

Diagnosis, nature of illness, or type of accident:

Date of first symptom or date of accident:	____/____/____ Month Day Year
Date of first consultation for this diagnosis, illness, or accident:	____/____/____ Month Day Year
Have similar symptoms occurred previously? YES ❍ NO ❍ If yes, when?	____/____/____ Month Day Year

❼ IN CASE OF HOSPITALIZATION

Name of hospital:

Period of hospitalization:	From: ____/____/____ Month Day Year	To: ____/____/____ Month Day Year

❽ TO BE COMPLETED BY TREATING PHYSICIAN

I certify that the information provided in sections 6 and 7 is complete and correct to the best of my knowledge.

Treating physician's signature and stamp:	Date: ____/____/____ Month Day Year

Name and address of provider:

Registration or license number:	Telephone:	E-mail:

❾ DETAILS OF THE SERVICE PROVIDED

Date of service	Service provider	Description of services rendered	Currency	Charges
____/____/____ Month Day Year				
____/____/____ Month Day Year				
____/____/____ Month Day Year				
____/____/____ Month Day Year				
____/____/____ Month Day Year				
____/____/____ Month Day Year				
Total charges				
Amount paid by the insured				
Amount paid by other insurance				
Balance due to hospital, clinic, doctor, etc.				

Policyholder's confirmation and authorization

AUTHORIZATION AND SIGNATURES

I certify that the above statements are complete and correct to the best of my knowledge, and that I am claiming benefits only for charges incurred by the patient named on this form.

Upon presentation of the original or photocopy of this signed authorization, I hereby authorize any medical professional, hospital, medical care institution, insurance support, pharmacy, governmental healthcare agency, insurance company, employer/group policyholder, employer benefit plan administrator and/or quality control company to release any and all past or present medical information and treatment concerning myself, my spouse or my dependents (if minors), and any and all statements of amounts due. I hereby authorize an employer/group policyholder or benefit plan administrator to provide USA Medical Services (third party administrator for the insurer) with financial or employment related information about myself, my spouse or any of my dependents (if minors). I understand that the information authorized herein will be used by USA Medical Services to evaluate this claim for insurance benefits, and that I or my legally authorized representative will receive a copy of this authorization upon request. Any confidential medical information obtained in assessing this claim will not be released to any person or organization EXCEPT the reinsurance companies or other entities performing contractual or legal services for the insurer or USA Medical Services in connection with this claim, or otherwise as permitted by law.

- ❍ In the event that I am represented by a producer, I hereby authorize that person to review the information provided on this Claim Form.

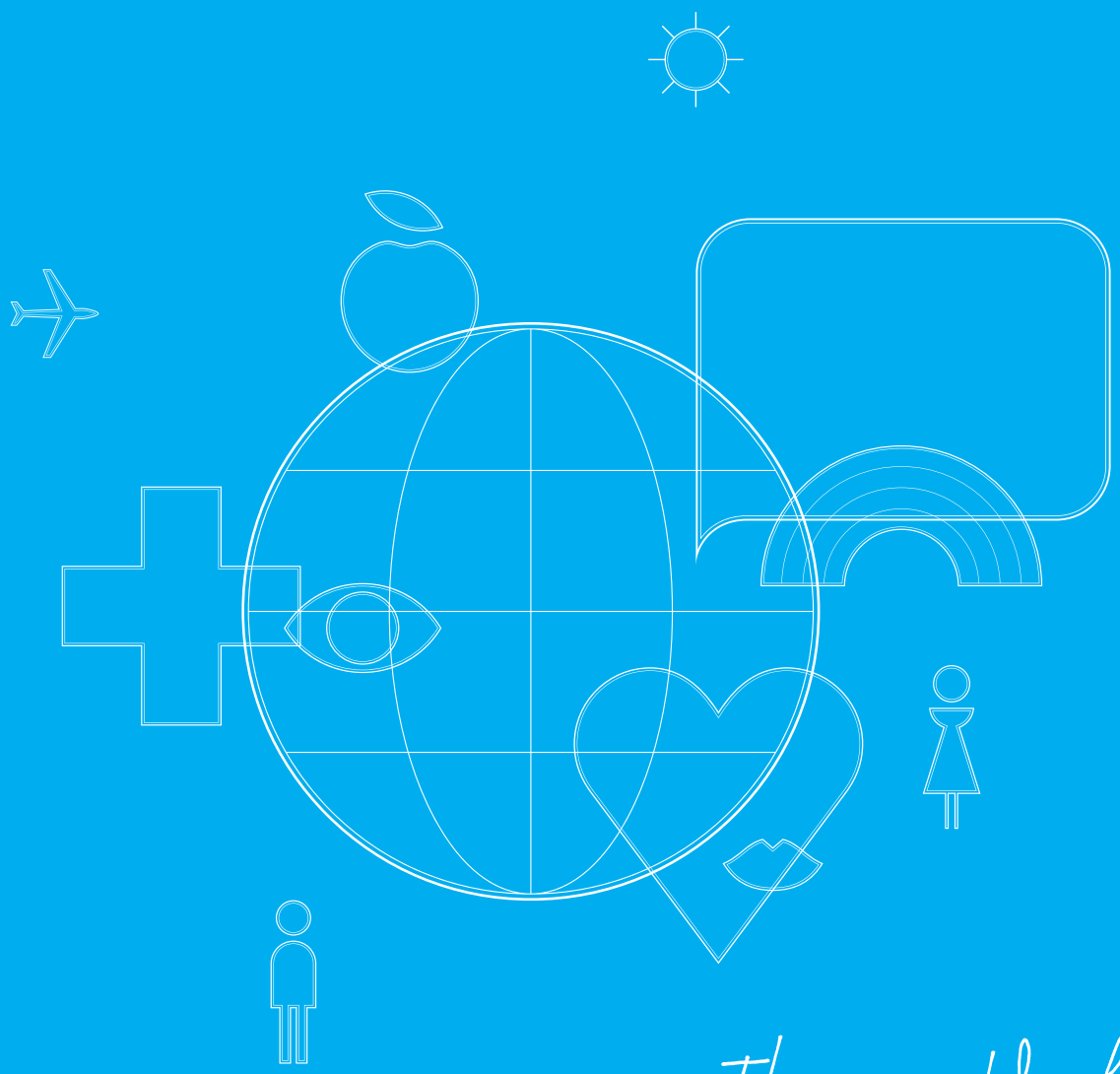
Policyholder's name (in BLOCK LETTERS):	
Policyholder's signature:	Date: _____/_____/_____ Month Day Year
Patient's name (in BLOCK LETTERS):	
Patient's signature (if 18 or older):	Date: _____/_____/_____ Month Day Year

For your convenience, we have created the check list below. Please check the relevant circles to make sure you have followed our guidelines.

- ❍ Please remember to **sign** the Claim Form.
- ❍ Please complete all sections of the Claim Form in full using **BLOCK CAPITALS**.
- ❍ Please have your **health care provider sign** and **stamp** the Claim Form.
- ❍ A **separate claim form** must be completed for **every patient** and **each incident**.
- ❍ When sending this Claim Form, please include **all original invoices** with proof of payment.
- ❍ **Laboratory costs** must include a list of the tests performed.
- ❍ **Pharmaceutical expenses** must include a list of all the medications acquired and a copy of the prescription.
- ❍ Please make sure that we have a copy of the **history of your present illness/condition**.
- ❍ For insured between the ages of 19 and 24, please submit **Certificate for Dependent Student** and a written statement signed by the policyholder attesting that the child's marital status is single.
- ❍ In case of a **surgical procedure** or **biopsy**, a pathology report must be included.
- ❍ In case of nasal trauma, **x-rays**, **radiology report**, and **emergency room report** must be included.
- ❍ When filing the first claim for a newborn child, copy of the **birth certificate** must be included.
- ❍ In case of an automobile accident, the **police report** must be included. If a police report cannot be obtained, please include a letter from the treating physician with a full description of the accident. Also include an explanation of benefits from the auto insurance company. If medical costs are not covered under the auto policy, include an explanation from the auto insurance company. If you do not have auto insurance, an explanatory letter will be required.
- ❍ If you have **another medical insurance policy**, the claim must first be processed by the other insurer and then presented to us with an explanation of how the claim was processed.

If you do not submit all of the required documents, your file will be closed while we wait for the missing document(s). This will delay the process and could be grounds for the claim to be denied.

7001 S.W. 97th Avenue
Miami, Florida 33173
Tel. +1 (305) 398 7400
Fax +1 (305) 275 8484
www.bupalatinamerica.com
bupa@bupalatinamerica.com



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