USA MEDICAL SERVICES
"When every second of your life counts"
A member of the Bupa group

Claim Form

1 POLICYHOLDER INFORMATION (to be completed by Policyholder)

1. Name of Policyholder	Policy Number	Date of Birth
Last / First / Middle Initial		month / day / year

Address:

E-mail address

2. Name of Patient	Date of Birth
Last / First / Middle Initial	month / day / year

Relationship to Policyholder ❍ Self ❍ Spouse ❍ Dependent Child

Do you have any other health insurance coverage? ❍ Yes ❍ No
Please give name of insurance company:

Date of Injury / Illness: month / day / year

Was condition related to:
A motor vehicle accident? ❍ Yes ❍ No (if Yes, please provide Police Report and Name/Policy number of your auto insurance.)

Name: Policy No.

Any other type of accident? ❍ Yes ❍ No (if Yes, please provide brief description of accident and any report that was generated therefrom.)

Reason why you sought medical care:

Date first consulted a doctor for this condition: month / day / year

Have you made payments for services rendered? ❍ Yes ❍ No If Yes, currency amount

AUTHORIZATON

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 a claim for insurance benefits, and that I or my legally authorized representative will receive a copy of this authorization upon request. Information obtained will not be released to any person or organization EXCEPT the reinsurance companies or other entities performing contractual or legal services for USA Medical Services in connection with this claim.

This authorization is valid for a period of twelve (12) months from the date signed.

Policyholder's Signature

Patient's Signature

(If 18 or older)

Please make sure your physician or provider completes Section 2 of this Form

2 PHYSICIAN OR PROVIDER INFORMATION (to be completed by Physician or Provider)

1. Physician or Provider Information

Are you the primary care physician? ❍ Yes ❍ No (if Yes, please sign below and give us your name and address.)

If not, please give us the name of the primary care physician: ______________________

2. Name of Patient / Insured			Date of Birth
Last	First	Middle Initial	month / day / year

3. Is condition related to an accident? ❍ Yes ❍ No (if Yes, please provide any pertinent report in your possession).

4. Date of illness or Injury ____/____/____ (month / day / year)

5. Date first consulted a doctor for this condition ____/____/____ (month / day / year)

6. Diagnosis or nature of illness or injury

1 ______________________

2 ______________________

3 ______________________

4 ______________________

7. For services related to a hospitalization, give hospitalization dates: Admitted ____/____/____ (month / day / year) Discharged ____/____/____ (month / day / year)

8. Fully describe procedures, medical services or supplies received for each given date.
Please be specific as to treatment rendered. The term "medical treatment" should not be used.

Date of service	Diagnosis (please indicate # from box 6)	Treatment/Service
month / day / year		
month / day / year		
month / day / year		
month / day / year		
month / day / year		
month / day / year		
month / day / year		
month / day / year		

9. Physician or Provider's signature ______________________

10. Physician/Provider's name and address: ______________________

____

Phone ______________________ Fax ______________________

3 Authorization for Claims Electronic Payment

I, ______________________________, Policy No. ______________

AUTHORIZE USA Medical Services to deposit in my bank account the funds corresponding to claims reimbursement.

Bank Information
(Please enclose a deposit slip that shows your bank account number)

Bank's Name ______________________________

Bank's Address ______________________________

Country ______________________________

ABA # ______________________ SWIFT # ______________________

Account No. ______________________ Account Holder ______________________

Additional Information, if necessary

Bank's Name ______________________________

Bank's Address ______________________________

Country ______________________________

ABA # ______________________ SWIFT # ______________________

Account No. ______________________ Account Holder ______________________

Comments

Policyholder's Signature ______________________ Date ____/____/____
month day year

Providing health insurance solutions
for Latin America and the Caribbean.

Administration:
7001 Southwest 97th Avenue
Miami, Florida 33173
Telephone: +1 (305) 398-7400
Fax: +1 (305) 275-8484
www.bupalatinamerica.com
bupa@bupalatinamerica.com

CF-01/2009-ENG