BUPA CORPORATE CARE CLAIM FORM

BEFORE YOU FILL OUT THE CLAIM FORM, PLEASE REVIEW THESE GUIDELINES:
☐ **Please make sure your provider completes sections 2 (treating physician), 3 (hospital) and 4 (other providers), including complete name, address, and Tax ID number.**
☐ Remember to sign the Claim Form.
☐ Complete all sections of the Claim Form in full using BLOCK CAPITALS.
☐ Have your health care provider sign and stamp the Claim Form.
☐ Complete a separate Claim Form for every patient and each incident.
☐ Include all original invoices with proof of payment.

PLEASE TAKE INTO CONSIDERATION THE FOLLOWING INFORMATION RELATED TO SPECIFIC TYPES OF CLAIMS:
☐ 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.
☐ 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 report must be included.
☐ When filing the first claim for a newborn child, a 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, 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 the medical costs are not covered under the auto insurance policy, include an explanation from the auto insurance company. If you do not have auto insurance, an explanatory letter will be required.

FAILURE TO COMPLETE SECTIONS 2, 3 AND 4 MAY RESULT IN THE DENIAL OF CLAIM.

IF YOU FILL OUT THE CLAIM FORM CORRECTLY AND SEND US ALL THE NECESSARY SUPPORTING DOCUMENTS, THE TIME NEEDED TO PROCESS YOUR CLAIM WILL BE GREATLY REDUCED.

IN CASE WE REQUEST ADDITIONAL INFORMATION TO ASSESS YOUR CLAIM, PLEASE REMEMBER THAT YOUR POLICY HAS A FILING LIMIT OF 180 DAYS. TO AVOID DENIAL OF YOUR CLAIM, PLEASE SUBMIT THE REQUESTED INFORMATION WITHIN THE FILING LIMIT.

Bupa Insurance Company
17901 Old Cutler Road, Suite 400 • Palmetto Bay, Florida 33157
Tel. +1 (305) 398 8266 • Fax +1 (305) 398 7333 • www.bupasalud.com/MyBupa

USA Medical Services • 24 hour emergency
Tel. +1 (305) 275 1500 • Fax +1 (305) 275 1518 • Toll free +1 (800) 726 1203 • www.bupasalud.com/MyBupa

1. PRINCIPAL MEMBER INFORMATION (to be completed by Principal Member)

Name	Last name / First name / M.I.	Member ID	
DOB	MM / DD / YY	E-mail address	
Address			
Home phone		Work phone	
Cell phone		Fax	

Do you have any other health insurance coverage? ☐ Yes ☐ No		Date of injury / illness	MM / DD / YY
Please give name of insurance company:			
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 number	
Was condition related to 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	MM / DD / YY
Have you made payments for services rendered? ☐ Yes ☐ No If Yes, indicate amount.	Currency	Amount	

ACKNOWLEDGEMENT

Any person who knowingly and with intent to defraud or deceive any insurance company by (1) filing an application for insurance or a claim containing any materially false information or (2) concealing or misleading information concerning any material fact, commits a fraudulent insurance act that may be considered a crime under applicable law.

I certify that all of the information supplied in this Claim Form is complete, true, and accurate.

AUTHORIZATION FOR PROVIDERS TO RELEASE HEALTH INFORMATION

Bupa Insurance Company and its Miami subsidiaries and affiliates (collectively "Bupa") may need to use my or my dependents' medical records, pescription medication records, treatment records and plans, or any other medical or pharmaceutical information which may be related to this claim. I hereby authorize any physician, hospital, lab, pharmacy, or any other health care provider, health plan, employer/group policyholder or benefit plan administrator, the Medical Information Bureau (MIB), or any other organization or person having any such medical information to disclose such information to Bupa or its Business Associates to evaluate this claim for insurance benefits. I understand that Bupa's ability to properly adjudicate my claim is dependent upon the receipt of all necessary health information. As such, my refusal to provide this authorization may result in the denial of this claim.

I understand that:

- I am entitled to receive a copy of this authorization.
- A copy of this authorization shall be as valid as the original.
- The authorization shall be valid throughout the life-cycle of the claim, including adjudication, auditing, and quality control activities.
- I have the right to revoke t his authorization by notifying Bupa in writing. However, the revocation will not be effective until Bupa receives and processes such revocation. Revocations shall be sent by postal or electronic mail to:

  Bupa Privacy Office
  17901 Old Cutler Road, Suite 400
  Palmetto Bay, Florida 33157 USA
  Privacyoffice@bupalatinamerica.com

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

I have reviewed and understand the content and purpose of this acknowledgement and authorization. By signing, I am confirming that the authorization decisions noted above accurately reflect my wishes.

Principal Member's signature		Date	MM / DD / YY
Patient's signature (if 18 or older)		Date	MM / DD / YY

2. TO BE COMPLETED BY TREATING PHYSICIAN

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:

Provider name				Tax ID number	
Address				Date	MM / DD / YY
Email		Telephone		Fax	

3. IN CASE OF HOSPITALIZATION

Name of hospital			Tax ID number	
Address				
Period of hospitalization	From		To	

4. OTHER PROVIDERS

Name of provider		Tax ID number	
Address			
Telephone		Date	MM / DD / YY

5. PATIENT INFORMATION

Name of Patient / Member		Date of Birth	MM / DD / YY
Date of illness or injury	MM / DD / YY	Date first consulted a doctor for this condition	MM / DD / YY

Diagnosis or nature of illness or injury

1	
2	
3	
4	
5	
6	
7	
8	

For services related to a hospitalization, give hospitalization dates:	Admitted	MM / DD / YY	Discharged	MM / DD / YY

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 (reference number in section above)	Treatment/Service	Cost of Treatment
MM / DD / YY			
MM / DD / YY			
MM / DD / YY			
MM / DD / YY			
MM / DD / YY			
MM / DD / YY			
MM / DD / YY			
MM / DD / YY			

Physician or provider’s signature		Date	
Physician or provider’s name			

6. AUTHORIZATION FOR CLAIMS ELECTRONIC PAYMENT

I,		Member ID:	
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.)			
Account holder			
Account number		☐ Checking	☐ Savings
Name of beneficiary bank			
ABA number (ACH transfers) (for banks in the USA only)		SWIFT code (for banks outside the USA)	
Branch number			
Branch address, and additional information			
Final account (if any)			
Name		Account number	
INTERMEDIARY BANK (PLEASE COMPLETE FOR TRANSFERS TO BENEFICIARY BANKS OUTSIDE THE USA)			
Name of bank		ABA / SWIFT /Other	
Address		Account number	

Comments			
Principal Member’s signature		Date	MM / DD / YY