CLAIM FORM

Diamond Care • Complete Care
P1 Diamond • P1 Gold • P1 Silver • Premier Care • Silver

BEFORE YOU FILL OUT THE CLAIM FORM, PLEASE REVIEW THESE GUIDELINES:
☐ **Please make sure your provider completes section 7 (hospitals), section 8 (treating physician), and/or section 9 (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.
☐ Make sure that we have a copy of the history of your present illness or condition.
☐ If you have another medical insurance policy, the claim must be processed first by the other insurer and then presented to Bupa with an explanation of how it was processed.

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.
☐ For dependents between the ages of 19 and 24, submit a Certificate of Dependent Student and a written statement signed by the policyholder attesting that the dependent'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 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 7, 8 AND 9 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 Limited
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USA Medical Services • 24 hour emergency
Tel. +1 (305) 275 1500, + 1 (800) 321 5187 • Fax +1 (305) 275 1490 • Toll free +1 (800) 726 1203 • www.bupasalud.com/MyBupa

1. POLICYHOLDER INFORMATION

Full name	Last name / First name / M.I.	Policy number	
DOB	MM / DD / YY	E-mail address	
Address			
Home phone		Work phone	
Cell phone		Fax	

2. 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	

3. 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

4. BANK ACCOUNT INFORMATION

Account holder					
Account holder address					
Zip Code		Country		Account number	
☐ Checking ☐ Savings		Account number			
Name of beneficiary bank				ABA number (ACH transfers)	For banks in the USA only
Branch number				SWIFT code	For banks outside the USA
Address and additional information					
City		Zip Code		Country	

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				City	
Zip Code		Country		Account number	

5. PATIENT INFORMATION

Full name	Last name	First name	M.I.	DOB	MM / DD / YY

Gender: ☐ M ☐ F

Relation to policyholder: ☐ Self ☐ Spouse ☐ Child

6. 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 then patient? ☐ Yes ☐ No

Place of accident ☐ Auto ☐ Home ☐ Work ☐ Other:

Diagnosis, nature of illness, or type of accident			
Date of first symptom or accident	MM / DD / YY	Date of first consultation for this diagnosis, illness, or accident	MM / DD / YY
Have similar symptoms occurred previously? ☐ Yes ☐ No		When?	MM / DD / YY

7. IN CASE OF HOSPITALIZATION

Name of hospital		Tax ID number	
Address			
Period of hospitalization	From MM / DD / YY	To	MM / DD / YY

8. 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.

Name of treating physician		Tax ID number	
Address			
Signature and stamp		Date	MM / DD / YY
		Registration/ license number	
E-mail		Telephone	

9. OTHER PROVIDERS

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

10. DETAILS OF THE SERVICE PROVIDED

Date of service	Service provider	Description of service	Currency	Charges
MM / DD / YY				
MM / DD / YY				
MM / DD / YY				
MM / DD / YY				
MM / DD / YY				
MM / DD / YY				
Total charges				
Amount paid by the insured				
Amount paid by other insurance				
Balance due to provider				

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.

The insurer, USA Medical Services, and/or any of their applicable related subsidiaries and affiliates will not engage in any transactions with any parties or in any countries where otherwise prohibited by the laws in the United States of America and, solely with respect to the insurer, where otherwise prohibited by the laws in the United Kingdom and/or Denmark. Please contact USA Medical Services for more information about this restriction.

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

DATA PROTECTION NOTICE

Purpose: Personal data collected about you and your dependents will be used by Bupa Insurance Limited (Bupa) to process your claims, collect premium, provide reimbursements, administer your policy, and to detect and prevent fraud or improper claims. If Bupa does not accept your application, your information may be recorded by us.

Confidentiality: Bupa complies with applicable data protection legislation and medical confidentiality guidelines. All correspondence concerning your policy will be sent to the policyholder and/or the intermediary. All insured persons on the policy may have access to correspondence and other information sent by Bupa or accessed at www.bupalatinamerica.com. Bupa uses third parties to process data on its behalf, and your data may be processed in or outside the European Economic Area (EEA). Bupa may exchange your information within the Bupa group and with your intermediary.
Medical information: Bupa may seek and exchange information about you and your dependents' health and treatment with those involved in your and your dependents' care (including your treating doctor and hospital) and their agents, and if applicable, any person or organization who may be responsible for meeting your and your dependents' treatment expenses, or their agents, as Bupa deems necessary.

Telephone calls: In the interest of continuously improving our service to customers, your call will be recorded and may be monitored.

Research: Aggregated data and data which has been made anonymous, may be used by Bupa, or disclosed to others, for research or statistical purposes.
Fraud: Information, including recorded telephone calls, may be disclosed to others with a view to preventing or detecting fraudulent or improper claims.
Names and addresses: Bupa does not make the names and addresses of customers available to other organizations (except as stated above).

Keeping you informed: Bupa would, on occasion, like to keep you informed of its products and services which it considers may be of interest to you. Data protection legislation gives you the right to see documents and information Bupa has recorded about you.

Contact address: If you do not wish to receive information about our products and services, or would like to see a copy of the information we hold about you, please write to the Bupa group Head of Information Governance at 1 Angel Court, London, EC2R 7HJ, England or at DataProtection@bupa.com.

AUTHORIZATION FOR PROVIDERS TO RELEASE HEALTH INFORMATION

I confirm that I (on behalf of myself and my dependents) have read the Data Protection Notice above, and give explicit consent for Bupa Insurance Limited and its Miami subsidiaries and affiliates (collectively "Bupa") to use my and/or my dependents' personal information in the manner and for the purposes stated. I accept that all correspondence concerning the insurance will be sent to the person registered as policyholder (which may be sent via our intermediary).

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 to Bupa. I hereby authorize any employer/group policyholder or benefit plan administrator to provide Bupa 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 Bupa 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 this authorization by notifying Bupa in writing and subject to and in accordance with 45 C.F.R. §164.508. 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
  18001 Old Cutler Road, Suite 500
  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.

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