

CLAIM FORM



☐ BEST DOCTORS INSURANCE LIMITED

Important: Please complete one form for each covered member presenting a claim.

☐ PRIMARY MEMBER

LAST NAME(S)

FIRST NAME(S)

POLICY NUMBER

DATE OF BIRTH (M/D/Y)

EMAIL ADDRESS

TELEPHONE (OFFICE OR MOBILE NUMBER)

☐ PATIENT

LAST NAME(S)

FIRST NAME(S)

DATE OF BIRTH (M/D/Y)

RELATIONSHIP TO PRIMARY MEMBER

- Self
- Spouse
- Child
- Other _____

☰ MEDICAL STATUS

A) Nature of disease or injury that requires treatment:

- Automobile accident (please provide police report)
- Other type of accident

PROVIDE BRIEF DESCRIPTION OF ACCIDENT AND ANY REPORT THAT WAS GENERATED THEREFROM

REASON OF MEDICAL CARE

IN CASE OF ACCIDENT, INDICATE DATE (M/D/Y)

Y N

Was there another person responsible?

If YES, provide details on a separate page and attach it to this form

Y N

B) Was the patient hospitalized? **If YES**, please complete the following:

NAME OF HOSPITAL

COUNTRY

NAME OF DOCTOR (WHO AUTHORIZED ADMISSION)

SPECIALTY

DATE OF ADMISSION (M/D/Y)

DATE OF DISCHARGE (M/D/Y)

Y N

C) Did the patient undergo surgery? **If YES**, indicate type of surgery:

TYPE OF SURGERY

DATE OF SURGERY (M/D/Y)

PLACE OF SURGERY

- Inpatient Hospital
- Outpatient Hospital
- Other place _____

Y N

D) Have you enclosed the bill(s)/receipt(s) for the medical service provided?

If YES, give the name of the doctor who ordered the medical service:

NAME OF DOCTOR

E) Indicate diagnosis, symptoms, disease or injury for which you are filing this claim form:

DIAGNOSIS

SYMPTOMS

ILLNESS/INJURY

DATE OF ONSET OF FIRST SYMPTOM (M/D/Y)

DATE ON WHICH YOU FIRST SAW THE DOCTOR FOR THIS REASON (M/D/Y)

☐ BILL/RECEIPT

What currency is used in the bill(s)/receipt(s)? _____

Attach to this claim form and list the originals of the itemized bill(s)/receipt(s) supplied by the provider:

1. NAME OF SERVICE PROVIDER	DATE OF SERVICE – FROM (M/D/Y)	
DESCRIPTION OF SERVICE	DATE OF SERVICE – TO (M/D/Y)	COST
2. NAME OF SERVICE PROVIDER	DATE OF SERVICE – FROM (M/D/Y)	
DESCRIPTION OF SERVICE	DATE OF SERVICE – TO (M/D/Y)	COST
3. NAME OF SERVICE PROVIDER	DATE OF SERVICE – FROM (M/D/Y)	
DESCRIPTION OF SERVICE	DATE OF SERVICE – TO (M/D/Y)	COST
4. NAME OF SERVICE PROVIDER	DATE OF SERVICE – FROM (M/D/Y)	
DESCRIPTION OF SERVICE	DATE OF SERVICE – TO (M/D/Y)	COST
5. NAME OF SERVICE PROVIDER	DATE OF SERVICE – FROM (M/D/Y)	
DESCRIPTION OF SERVICE	DATE OF SERVICE – TO (M/D/Y)	COST

TOTAL OF ALL CHARGES
 FOR WHICH REIMBURSEMENT IS REQUESTED
 (INDICATE IN THE CURRENCY THAT APPEARS
 IN THE BILL/RECEIPT)

☐ AUTHORIZATION

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 statement of amounts due.

I understand that the information authorized herein will be used by Best Doctors Insurance Limited (the 'Insurance Company'), to evaluate a claim for insurance benefits, and that I or my 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, my agent of record, or other entities performing contractual or legal services for the Insurance Company, in connection with this claim.

_____ PRIMARY MEMBER'S SIGNATURE	_____ PATIENT'S SIGNATURE (OR LEGAL GUARDIAN)
_____ DATE (M/D/Y)	_____ DATE (M/D/Y)

☐ SELECT REIMBURSEMENT METHOD

- Cheque**
- Wire transfer** (only banks established in the United States. Provide copy of a void cheque)

I, _____,
 authorize Best Doctors Insurance Limited to deposit the funds for reimbursement of the approved claim amount.
 I understand that I am fully responsible for the charges this transaction may generate.

_____ APPLICANT'S SIGNATURE	_____ DATE (M/D/Y)
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⋮ WHEN SHOULD I NOTIFY?

Emergencies: Notify Best Doctors **within 48 hours**

Elective Admissions/Inpatient/Outpatient/Scheduled MRI/CTServices/Other Procedures:
Notify Best Doctors **72 hours prior** to the service date.

If you do not notify Best Doctors, you will be responsible for 30% of all covered costs.

Best Doctors Notification Center is open 24 hours a day, 7 days a week.

⋮ WHO SHOULD I CONTACT?

Please call our Notification Center with the following information:

- ◆ Patient name
- ◆ Date of birth
- ◆ Policy number
- ◆ Diagnosis
- ◆ Estimated length of stay
- ◆ Proposed treatment
- ◆ Estimated cost (if available)
- ◆ Medical records

⋮ WHERE TO SUBMIT CLAIMS?

Within USA

Best Doctors Claims Center
5301 Blue Lagoon Drive, Suite 620
Miami, Florida 33126

Within Trinidad and Tobago

Best Doctors Claims Center
c/o Global Financial Brokers
92 Tragarete Road
Port of Spain, Trinidad W.I

⋮ THE PROCESS TO FOLLOW

Please submit the following information:

- ◆ Original itemized bills (photocopies will not be accepted)
- ◆ Medical records that Best Doctors considers necessary
- ◆ Any available police report (if applicable)