MEDICAL EXPENSES CLAIM FORM

## PROCEDURE FOR FILING A CLAIM

1. Please avoid making a series of small claims. It makes sense to accumulate your small medical and dental bills until you have enough to justify a significant reimbursement. Then take the precaution of making photocopies of all documents before sending the originals to MEDICAL ADMINISTRATORS INTERNATIONAL.
2. If your spouse or children are covered by Social Security, another government plan or another group insurance policy, you must obtain the reimbursement to which you are entitled before filing this claim. In this case enclose with your claim a copy of all medical and dental bills relating to the claim, as well as the original statement of Social Security or other plan prior reimbursement.
3. Answer all questions on both sides of the claim form and attach to it the originals of all reimbursable bills. Bills should indicate name and date of birth of patient, date of treatment, a detailed description of medical services and the amount of charges corresponding to each category of treatment or service. Pharmacy bills should identify drugs purchased (name and cost per item). Bills must specify name and address of medical provider or pharmacy. Cash receipts which do not provide this information are not acceptable.
4. A bill for eyeglasses, contact lenses, prescription drugs, laboratory tests, physical therapy or chiropractic treatment must be accompanied by a copy of the doctor's prescription.
5. If a treatment costs more than 300 USD or 300 Euros, please have the physician complete and sign Section E on the claim form.
6. Fill in this claim form carefully and mail it within twelve months of treatment to:

## Section A – Insured Member

* 1. Family Name:

3. Insurance I.D. Number

5. Telephone N°:

* 1. First Name:

4. Date of Birth:

1. E-mail:
2. Mailing Address:

Country:

Postal Code:

*If your bank account changed recently, please attach an account identification form and specify currency*:

**Section B - Patients listed on this claim form**

1. Full Name
2. Relationship to Insured

3. Social Security/Other Plan

a.

b.

c.

d.

Yes

Yes Yes Yes

No

No No No

4.Are you or your spouse or your children covered under any other group plan, H.M.O., Social Security

or government plan, or individual insurance policy which will pay for any of the expenses of this claim ?

No Yes - If yes, please identify plan and describe benefits:

***Please complete in block letters and answer reverse side***

**Section C - Services / Supplies (Use one line for each health care bill)**

If any of the above is a result of an accident, please specify:

Automobile

Work-Related

Other

1. Circumstances of accident:
2. Date and place of accident:
3. N° of bills above related to accident (*example* 1, 3, 6):

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Date of Services | First Name of Patient | Description of Medical/Dental Services, Procedures, or Supplies | Diagnosis or Cause For Medical Service | Charges & Currency | Doctor or Location of Service |
| (Day/month/year**)** |  |  |  |  |  |
| 1. |  |  |  |  |  |
| 2. |  |  |  |  |  |
| 3. |  |  |  |  |  |
| 4. |  |  |  |  |  |
| 5. |  |  |  |  |  |
| 6. |  |  |  |  |  |

**Section D – Signature**

I hereby certify that the information provided is correct and true to the best of my knowledge.

Signature of Employee:

Date:

**Section E - Physician or provider (this section must be completed by the physician for all treatment exceeding $300 or €300)**

1.

2.

3.

Is the cause a work-related accident ?

Diagnosis of illness or injury ?

Yes

No A transport accident ?

Yes

No

History of this or any related condition with dates on which previous treatment took place:

1. Description of treatment:
2. Please print your name: Address:

6.

7.

Telephone:

Fax:

1. Signature of physician:
2. Date: