

Bupa Secure Care BVI Claim Form



1. POLICYHOLDER INFORMATION (to be completed by Policyholder)

Name of policyholder		Policy Number (#)	Date of birth
_____	_____	_____	____/____/____ month day year
Last	First	Middle Initial	
Mailing Address _____			
E-mail address _____		Telephone Number _____	
Name of patient			Date of birth
_____			____/____/____ month day year
Last			First
Middle Initial			
Relationship to Policyholder <input type="radio"/> Self <input type="radio"/> Spouse <input type="radio"/> Dependent child			
Do you have any other health insurance coverage? <input type="radio"/> Yes <input type="radio"/> No		Date of injury / illness: ____/____/____	
Please provide name of insurance company: _____		month day year	
Was condition related to:			
A motor vehicle accident? <input type="radio"/> Yes <input type="radio"/> No (if Yes, please provide police report and name/policy number of your auto insurance.)			
Name: _____		Policy No. _____	
Any other type of accident? <input type="radio"/> Yes <input type="radio"/> 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? <input type="radio"/> Yes <input type="radio"/> No If Yes, currency _____ amount _____			

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 group 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 group administrator to provide USA Medical Services (third party administrator for Bupa Insurance Company) 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. Medical records received by Bupa Insurance Company are not subject to the privacy provisions of the Health Insurance Portability and Accountability Act (HIPAA). This Authorization is valid for a period of twelve (12) months from the date signed.

 Policyholder's signature ____/____/____
Date

 Patient's signature ____/____/____
Date
 (if 18 or older)

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

3. AUTHORIZATION FOR CLAIMS ELECTRONIC PAYMENT

I, _____, Policyholder ID: _____

AUTHORIZE USA Medical Services to deposit in my bank account the funds corresponding to my 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 # _____

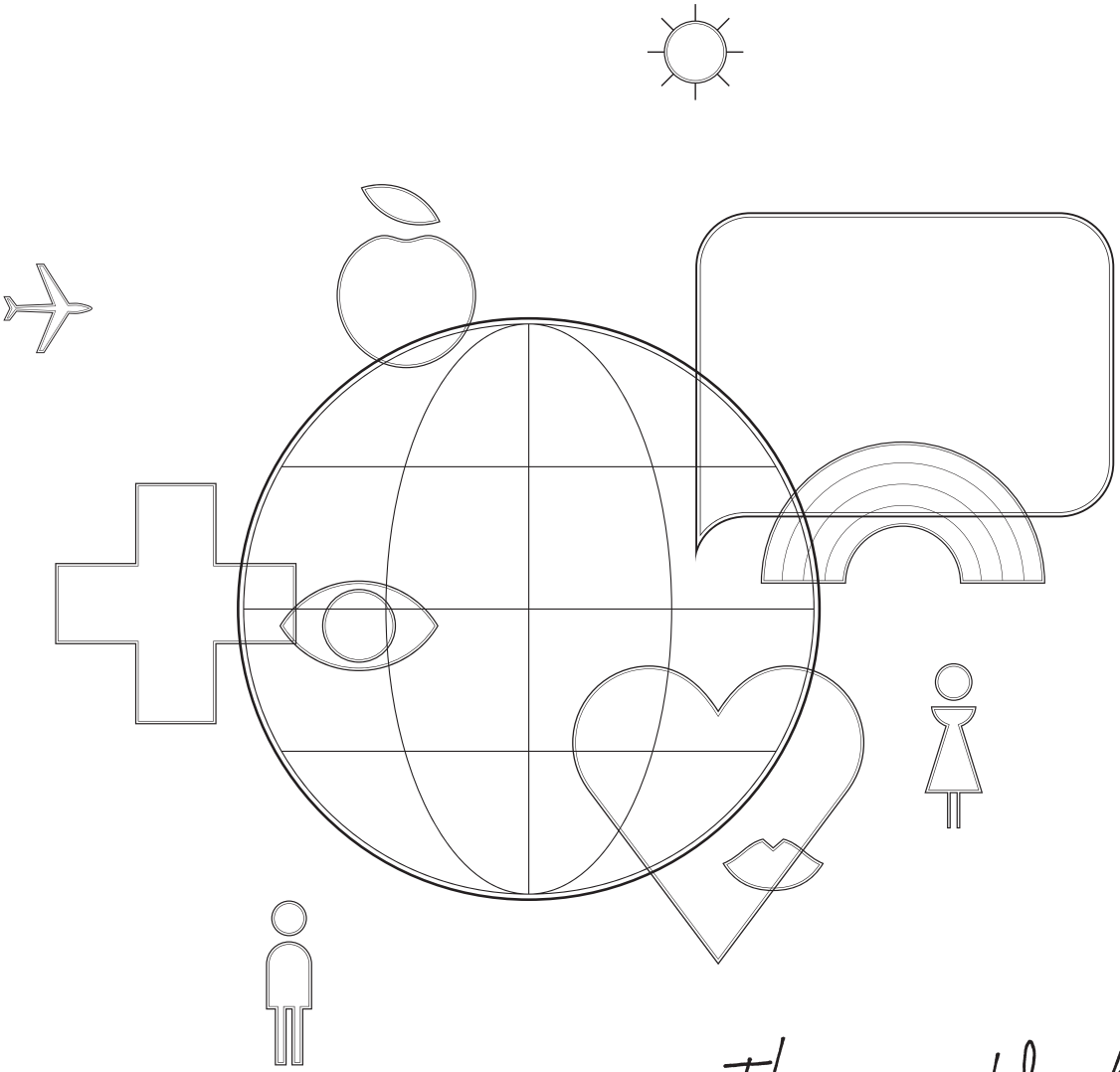
Account No. _____ Account holder _____

Comments

Policyholder's signature _____ Date month / day / year

—

7001 S.W. 97th Avenue
Miami, Florida 33173
Tel. +1 (284) 496 2872
Tel. +1 (305) 398 8266
Fax +1 (305) 398 7333
www.bupalatinamerica.com
corporatecare@bupalatinamerica.com



The world of Bupa