COMPLETION INSTRUCTIONS FOR MEDICAL EXPENSE CLAIM FORM

Read the form carefully and answer all of the pertinent questions as completely as possible. An incomplete form may delay the processing of your claim. Benefits are paid for eligible medical expenses which are not eligible for reimbursement by your primary medical insurance. Claims should be filed with the primary medical insurance before submitting this claim as you may not be aware that your primary medical insurance covers out of the country claims. If they do not we require the denial in writing from them.

- All Claimants should fully complete the Medical Expense Claim Form;
- Please make sure you attach a copy of your medical insurance card if you have one
- Include the originals of the medical and pharmacy bills along with the original paid receipts, without the receipts for payment we will not be able to pay you
- If you paid these charge with cash, please submit the documentation that shows where the funds were obtained, if by credit card send the copy of the receipts or summary
- If you have obtained any medical records, please attach them for review
- Attach a copy of your flight itinerary and a copy of your passport with the travel dates and ID to support home country

Your completed claim form and all supporting documentation should be submitted to the following address:

MEDEX Insurance Services
PO Box 740004
Atlanta, GA 30374

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MEDICAL EXPENSE CLAIM FORM

Please fully complete this Claim Form and return it along with the signed Authorization and all original cash, credit card receipts and original invoices to the address below. We also require a copy of your flight itinerary and copies of the front page of the passport and the dates traveled that are stamped on the passport.

MEDEX Insurance Services
PO Box 740004
Atlanta, GA 30374

Part A: To be completed by insured person

Claimant's Name: ______________________________ Male: ___ Female: ___
Mailing Address: ______________________________ Date of Birth __/__/__
______________________________ Policy ID No.______________
Home Phone No. _______________________ Email Address: __________________________

Do you or a member of your family have **any** medical insurance through your employer, school or other organization?

Yes: _______ No: _______

If yes, please provide the name and phone number of the company, and your policy number and attach copy of the medical card:

____
____

Part B: Complete this section if claim is the result of an injury

1. Was the Emergency Response Center notified? Yes: ____ No: _____
   If yes, when?_________________________________
2. Date and location of the injury:____
3. Describe the injury and how it occurred: ____
   ____
4. Name and address/fax number of the physician or hospital where you were treated:
   ____
   ____
5. What date did you first seek treatment for this injury? _________________________
6. What is the name and address/fax number of your primary care physician in your home area?
   ____
   ____

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Part C: Complete this section if claim is the result of an illness

1. Was the Emergency Response Center notified? Yes:____ No:____ If yes, when?____________________

2. Date you first noticed the symptoms that led you to seek treatment:

____

____

3. Describe the illness and give the actual diagnosis of the condition: ________________________________

____

____

4. Name and address/fax number of the physician or hospital where you were treated:

____

____

5. What date did you first seek treatment for this illness? _________________________

6. Have you ever had this illness or similar condition before? Yes____ No_____

If so, when and where did the injury occur and what was the name and address of the treating physician?

____

____

7. What is the name and address/fax number of your primary care physician in your home area?

____

____

Any person who knowingly and with intent to defraud any insurance company or other person, files a statement of claim containing any materially false or misleading information or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and, in some states, a felony.

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Date:
To:
Case #

AUTHORIZATION FOR RELEASE OF INFORMATION

In order to process a claim for benefits, I authorize my physician, hospital or other medical provider to release to MEDEX Assistance or its representative, any information regarding my medical history, symptoms, treatment, examination results or diagnosis. A photocopy of this authorization shall be considered as effective and valid for the duration of the claim, but not to exceed one year from the date signed. I understand I have the right to receive a copy of this authorization.

I understand that if the person or entity that gives or receives the above information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.

I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken by the MEDEX in reliance on this authorization, by sending a written revocation to: MEDEX Insurance Services, PO Box 740004, Atlanta, GA 30374

I understand that I am not required to sign this authorization form and that MEDEX will not condition the provision of payment of benefits on the signing of this authorization, except the MEDEX may condition evaluating insurance coverage or eligibility for benefits on provision of this authorization if the authorization sought is for insurance coverage evaluation or insurance coverage eligibility relating to the Insured. This authorization will expire 24 months from the date this authorization is signed.

Insured Name (Print):_________________________________ Date of Birth: __________

Insured Signature: ___________________________________ Date: _________________

Note: If Patient/Employee is a minor or is incapacitated, Parent or Guardian must sign.
If Patient/Employee is deceased, Personal Representative or next of kin must sign.

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