Compañía de Seguros, S.A.

MEDICAL EXPENSES CLAIM FORM

Please answer each question carefully for avoid delays in the claim process

Section A (must be completed by the insurer)

1. Full name of the policyholder	2. ID Number	3. Policy number
4. Insurer address		
5. Name of Patient	6. Relationship to Policy holder ☐ Spouse ☐ Dependent Child	7. Date of Birth MM DD YY / /
8. Work Address or College		9. Full time student? ☐ Yes ☐ No
10. Do you have any other health insurance coverages?	11. Email address:	
12. Did you do pre-notification of this claim? ☐ Yes ☐ No	13. If yes, who did the pre-notification?	14. Date of Pre-notification MM DD YY / /

To complete in case of Accident.

15. Date of Injury MM DD YY / / Hour:	16. Brief description of Accident:

To complete in case of Illlness

17. Date of first symptom MM DD YY / /	18. Describe illness

19. Did you received treatment before caused by the same illness? ☐ Yes ☐ No. If yes, describe date and others.

20. Name of the physician	21. Physician address

AUTHORIZATION

I authorize to any hospital, clinics and doctor, or any other medical services, Medical Bureau o any other institution that have information about my health, health spouse or dependents, to give this information to ASSA Compañía de Seguros S.A.

SIGNATURE OF PRINCIPAL INSURER	**SIGNATURE OF PATIENT** (IF PATIENT IS MORE THAN 18 YEARS OLD)	**DATE** / / **MM D D YY**

Section B: Information must be completed by the doctor

1. Full name of patient	
2. Have the insurer other health insurance policies, name of the insurance company and policy number	
3. ☐ Pregnant ☐ Illness ☐ Injury or Accident	Date of Illness Or first symptom MM / DD / YY
4. ¿Has the patient a treatment before this condition? Please give details:	
5. Date first consulted :	
6. Diagnosis or nature of illness or injury	
7. Name of Physician or Provider	

8. Fully describe procedures, medical services or supplies received for each given date

Date of services	Place of services	Describe procedures, medical services, others	Charges

Physician/ Provider's name	Address	Phone numbers
Physician/Provider's Identification Number	Number of Medical License	
Physicians / Provider's signature Place and Date _____ _____ / ____ / _____	Seal	