

BUPA CORPORATE CARE CLAIM FORM



BEFORE YOU FILL OUT THE CLAIM FORM, PLEASE REVIEW THESE GUIDELINES:

- Please make sure your provider completes sections 2 (treating physician), 3 (hospital) and 4 (other providers), including complete name, address, and Tax ID number.
- Remember to sign the Claim Form.
- Complete all sections of the Claim Form in full using BLOCK CAPITALS.
- Have your health care provider sign and stamp the Claim Form.
- Complete a separate Claim Form for every patient and each incident.
- Include all original invoices with proof of payment.

PLEASE TAKE INTO CONSIDERATION THE FOLLOWING INFORMATION RELATED TO SPECIFIC TYPES OF CLAIMS:

- Laboratory costs must include a list of the tests performed.
- Pharmaceutical expenses must include a list of all the medications acquired and a copy of the prescription.
- In case of a surgical procedure or biopsy, a pathology report must be included.
- In case of nasal trauma, x-rays, radiology report, and emergency report must be included.
- When filing the first claim for a newborn child, a copy of the birth certificate must be included.
- In case of an automobile accident, the police report must be included. If a police report cannot be obtained, include a letter from the treating physician with a full description of the accident. Also include an explanation of benefits from the auto insurance company. If the medical costs are not covered under the auto insurance policy, include an explanation from the auto insurance company. If you do not have auto insurance, an explanatory letter will be required.

FAILURE TO COMPLETE SECTIONS 2, 3 AND 4 MAY RESULT IN THE DENIAL OF CLAIM.

IF YOU FILL OUT THE CLAIM FORM CORRECTLY AND SEND US ALL THE NECESSARY SUPPORTING DOCUMENTS, THE TIME NEEDED TO PROCESS YOUR CLAIM WILL BE GREATLY REDUCED.



Bupa

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USA Medical Services • 24 hour emergency

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1. PRINCIPAL MEMBER INFORMATION (to be completed by Principal Member)

| | | | | |
|------------|--------------|----------------|------------|-----------|
| Name | Last name | First name | M.I. | Member ID |
| DOB | MM / DD / YY | E-mail address | | |
| Address | | | | |
| Home phone | | | Work phone | |
| Cell phone | | | Fax | |

| | | | |
|--|--|---|--|
| Do you have any other health insurance coverage? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Date of injury / illness | MM / DD / YY |
| Please give name of insurance company: | | | |
| Was condition related to a motor vehicle accident? | <input type="checkbox"/> Yes <input type="checkbox"/> No | (If Yes, please provide Police Report and Name/Policy number of your auto insurance.) | |
| Name | | | Policy number |
| Was condition related to any other type of accident? | <input type="checkbox"/> Yes <input type="checkbox"/> 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 |
| MM / DD / YY | | | |
| Have you made payments for services rendered? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Currency | Amount |
| If Yes, indicate amount. | | | |

ACKNOWLEDGEMENT

Any person who knowingly and with intent to defraud or deceive any insurance company by (1) filing an application for insurance or a claim containing any materially false information or (2) concealing or misleading information concerning any material fact, commits a fraudulent insurance act that may be considered a crime under applicable law.

I certify that all of the information supplied in this Claim Form is complete, true, and accurate.

AUTHORIZATION FOR PROVIDERS TO RELEASE HEALTH INFORMATION

USA Medical Services and its Miami subsidiaries and affiliates (collectively "Bupa") may need to use my or my dependents' medical records, prescription medication records, treatment records and plans, or any other medical or pharmaceutical information which may be related to this claim. I hereby authorize any physician, hospital, lab, pharmacy, or any other health care provider, health plan, employer/group policyholder or benefit plan administrator, the Medical Information Bureau (MIB), or any other organization or person having any such medical information to disclose such information to Bupa or its Business Associates to evaluate this claim for insurance benefits. I understand that Bupa's ability to properly adjudicate my claim is dependent upon the receipt of all necessary health information. As such, my refusal to provide this authorization may result in the denial of this claim.

I understand that:

- I am entitled to receive a copy of this authorization.
- A copy of this authorization shall be as valid as the original.
- The authorization shall be valid throughout the life-cycle of the claim, including adjudication, auditing, and quality control activities.
- I have the right to revoke this authorization by notifying Bupa in writing. However, the revocation will not be effective until Bupa receives and processes such revocation. Revocations shall be sent by postal or electronic mail to:

Bupa Privacy Office
17901 Old Cutler Road, Suite 400
Palmetto Bay, Florida 33157 USA
Privacyoffice@bupalatinamerica.com

In the event that I am represented by a producer, I hereby authorize that person to review the information provided on this Claim Form.

I have reviewed and understand the content and purpose of this acknowledgement and authorization. By signing, I am confirming that the authorization decisions noted above accurately reflect my wishes.

| | | |
|--------------------------------------|------|--------------|
| Principal Member's signature | Date | MM / DD / YY |
| Patient's signature (if 18 or older) | Date | MM / DD / YY |

2. TO BE COMPLETED BY TREATING PHYSICIAN

Are you the primary care physician? Yes No (If Yes, please sign below and give us your name and address.)
 If not, please give us the name of the primary care physician:

| | | | | |
|---------------|--|-----------|---------------|--------------|
| Provider name | | | Tax ID number | |
| Address | | | Date | MM / DD / YY |
| Email | | Telephone | | Fax |

3. IN CASE OF HOSPITALIZATION

| | | | | |
|---------------------------|------|--|---------------|--|
| Name of hospital | | | Tax ID number | |
| Address | | | | |
| Period of hospitalization | From | | To | |

4. OTHER PROVIDERS

| | | | | |
|------------------|--|--|---------------|--------------|
| Name of provider | | | Tax ID number | |
| Address | | | | |
| Telephone | | | Date | MM / DD / YY |

5. PATIENT INFORMATION

| | | | | |
|--|--------------|--|---------------|--------------|
| Name of Patient / Member | | | Date of Birth | MM / DD / YY |
| Date of illness or injury | MM / DD / YY | Date first consulted a doctor for this condition | MM / DD / YY | |
| Diagnosis or nature of illness or injury | | | | |
| 1 | | | | |
| 2 | | | | |
| 3 | | | | |
| 4 | | | | |
| 5 | | | | |
| 6 | | | | |
| 7 | | | | |
| 8 | | | | |
| For services related to a hospitalization, give hospitalization dates: | Admitted | MM / DD / YY | Discharged | MM / DD / YY |

Fully describe procedures, medical services or supplies received for each given date.
Please be specific as to treatment rendered. The term "medical treatment" should not be used.

| Date of service | Diagnosis (reference number in section above) | Treatment/Service | Cost of Treatment |
|-----------------|---|-------------------|-------------------|
| MM / DD / YY | | | |
| MM / DD / YY | | | |
| MM / DD / YY | | | |
| MM / DD / YY | | | |
| MM / DD / YY | | | |
| MM / DD / YY | | | |
| MM / DD / YY | | | |
| MM / DD / YY | | | |
| MM / DD / YY | | | |

| | | | |
|-----------------------------------|--|------|--------------|
| Physician or provider's signature | | Date | MM / DD / YY |
| Physician or provider's name | | | |

6. AUTHORIZATION FOR CLAIMS ELECTRONIC PAYMENT

| | | | |
|---|--|--|----------------------------------|
| I, | | Member ID: | |
| AUTHORIZE USA Medical Services to deposit in my bank account the funds corresponding to claims reimbursement. | | | |
| Bank Information (Please enclose a deposit slip that shows your bank account number.) | | | |
| Account holder | | | |
| Account number | | <input type="checkbox"/> Checking | <input type="checkbox"/> Savings |
| Name of beneficiary bank | | | |
| ABA number (ACH transfers) <small>(for banks in the USA only)</small> | | SWIFT code <small>(for banks outside the USA)</small> | |
| Branch number | | | |
| Branch address, and additional information | | | |
| Final account (if any) | | | |
| Name | | Account number | |
| INTERMEDIARY BANK (PLEASE COMPLETE FOR TRANSFERS TO BENEFICIARY BANKS OUTSIDE THE USA) | | | |
| Name of bank | | ABA / SWIFT / Other | |
| Address | | Account number | |
| Comments | | | |
| | | | |
| | | | |
| | | | |
| Principal Member's signature | | Date | MM / DD / YY |