# MEDICAL CLAIM FORM

Please mail completed Claim Form with itemized bills and receipts to:
***(To expedite your claim, please fax it with readable receipts*)**


ACE USA
PO Box 5124
Scranton, PA 18505-0556

(800) 336-0627 Inside USA
(302) 476-6194 Outside USA
(302) 476-7857 Facsimile
diane.basa@acegroup.com


***Please complete Sections A, B, C & E. Complete Section D if the claim is for a dependent, other coverage is in effect, or if the claim is accident related. Complete a separate Claim Form for each individual.***

## SECTION A. EMPLOYEE/PATIENT INFORMATION

Policyholder: _____ Policy**:**_____

Patient's Name _____ Patient's Date of Birth _____

Home Address _____

***Please provide telephone and facsimile numbers, with country and city codes.***

Home #_____ Work # _____ Fax #_____ E-mail_____

Leader's Name _____ Work #_____ Fax # _____ E-mail_____

## SECTION B. TRAVEL INFORMATION *Please complete this section*

My home country _____

I / we left the above country on (Day / Month / Year) _____

I / we visited the following countries _____

I / we are expected to return home on (Day / Month / Year) _____

The purpose of my / our trip was _____

## SECTION C. PAYMENT INFORMATION *Please complete either Option #1 or Option # 2*

☐ OPTION #1 **Payment to CLAIMANT.** ***Indicate where you wish the payment to be sent and in what currency.***
μ **Your home address as listed above**

☐ OPTION #2 - **Payment to a Provider, e.g. hospital, physician**
Please complete Provider's name and address in Section E of this Claim Form

☐ OPTION #3 **Payment to the Policyholder**

Policyholder's Name: _____

Policyholder's Address: _____

Payment Authorization: I authorize payment directly to me or to the healthcare provider in Section E of this Claim Form.

**PATIENT'S SIGNATURE_____ DATE _____**

Patient's Signature and Release (Parent or Guardian, if claim is for a minor), I certify, to the best of my knowledge, that this Claim Form does not contain any false, misleading, or incomplete information. I authorize the release of all records or other information which may be necessary to determine claim payment.

**PATIENT'S SIGNATURE: _____ DATE:_____**

**SECTION D. OTHER COVERAGE INFORMATION**

*Complete only if the claim is for a dependent and/or other coverage is in effect or if the claim is accident or work related.*

Do you have any other insurance? ☐ Yes ☐ No If yes, please provide source of insurance.

Please indicate source _____

Is this claim accident related? ☐ Yes ☐ No Is this claim worked related? ☐ Yes ☐ No

If yes, please provide documents relating to accident or work injury.

If claim is due to an accident, are you seeking reimbursement from another source? ☐ Yes ☐ No

Please indicate source _____

Spouse's name _____ Spouse's insurance company _____

Spouse's employer and telephone # _____

Dependent's date of birth _____ Is your dependent a full-time student? ☐ Yes ☐ No

*If yes, please provide documentation of current academic registration.*

**AUTHORIZATION and ASSIGNMENT OF BENEFITS**

I, the undersigned authorize any hospital or other medical-care institution, physician or other medical professional, pharmacy, Insurance support organization, governmental agency, group policyholder, Insurance company, association, employer or benefit plan administrator to furnish to the Insurance Company named above or its representatives, any and all information with respect to any injury or sickness suffered by, the medical history of, or any consultation, prescription or treatment provided to, the person whose death, injury, sickness or loss is the basis of claim and copies of all of that person's hospital or medical records, including information relating to mental illness and use of drugs and alcohol, to determine eligibility for benefit payments under the Policy Number identified above. I authorize the policyholder, employer or benefit plan administrator to provide the Insurance Company named above with financial and employment-related information. I understand that this authorization is valid for the term of coverage of the Policy identified above and that a copy of this authorization shall be considered as valid as the original.

I *agree* that a photographic copy of this Authorization shall be a valid as the original.
I understand that I or my authorized representative may request a copy of this authorization.
I understand that I or my authorized representative may revoke this authorization at any time by providing the insurance company with written notification as to my intent to revoke.

| Signature of Insured or Authorized Representative | Relationship, If Other Than Insured | Dated |
|---|---|---|

Address:

**Fraud Warning:** Certain states require specific state mandated fraud language to be included on all claims forms while other states use a generalized fraud stated. ACE USA Accident &Health has adopted the fraud warning language prescribed by the District of Columbia as its standard fraud statement. Unless otherwise noted below this statement shall be included on all claims forms, applications and enrollment forms.

**District of Columbia Generic Warning:**
It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and / or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

**The following states have required us to use state specific language as follows:**

**California**
For your protection California law requires the following to appear on this form:
Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

**Colorado**
It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages.

**Florida**
Any person who knowingly and with intent in injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

**New York**
Any person who knowingly and with to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed $5,000 and the stated value of the claim for each such violation.

**Oklahoma**
WARNING: ny person who knowingly, and with intent to injure, defraud or deceive any insurer, makes ant claim for the process of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

**Pennsylvania:**
Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

**Maryland/Oregon**
Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

**Virginia**
Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer submits an application or files a claim containing a false or deceptive statement may have violated state law.

**SECTION E. PHYSICIAN OR PROVIDER** *Please complete this section.*

Name, address, and telephone # of physician or provider of service_____

_____

Diagnosis or nature of illness or injury _____

Date of illness (first symptom) or injury _____ Date first consulted for this condition _____

Hospital confinement dates: From _____ To _____ Date able to return to work _____

Total disability dates: From _____ To _____ Partial disability dates: From_____ To _____

Patient's account # _____ Amount paid _____ Balance due _____

| Place of service _____ Diagnosis code and description _____ | | | |
|---|---|---|---|
| **Date of Service** | **Procedure code and description/ Predetermination of benefits** | **Charges** | **Total charges** |
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