CLAIM FORM

For Bupa Insurance Company (BIC) products only

BEFORE YOU FILL OUT THE CLAIM FORM, PLEASE REVIEW THESE GUIDELINES:
☐ **Please make sure your provider completes section 7 (hospitals), section 8 (treating physician), and/or section 9 (other providers), including complete name, address, and Tax ID number.**
☐ This form should be used for Bupa Insurance Company (BIC) products only. To verify if you have a BIC product, check your Membership Guide, Agreement clause 1.1.
☐ 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.
☐ Make sure that we have a copy of the history of your present illness or condition.
☐ If you have another medical insurance policy, the claim must be processed first by the other insurer and then presented to Bupa with an explanation of how it was processed.

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.
☐ For dependents between the ages of 19 and 24, submit a Certificate of Dependent Student and a written statement signed by the policyholder attesting that the dependent's marital status is single.
☐ 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 7, 8 AND 9 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.

IN CASE WE REQUEST ADDITIONAL INFORMATION TO ASSESS YOUR CLAIM, PLEASE REMEMBER THAT YOUR POLICY HAS A FILING LIMIT OF 180 DAYS. TO AVOID DENIAL OF YOUR CLAIM, PLEASE SUBMIT THE REQUESTED INFORMATION WITHIN THE FILING LIMIT.

Bupa Insurance Company
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USA Medical Services • 24 hour emergency
Tel. +1 (305) 275 1500 • Fax +1 (305) 275 1518 • Toll free +1 (800) 726 1203 •www.bupasalud.com/MyBupa

1. POLICYHOLDER INFORMATION

Full name	Last name / First name / M.I.	Policy number	
DOB	MM / DD / YY	E-mail address	
Address			
Home phone		Work phone	
Cell phone		Fax	

2. CLAIM AGAINST OTHER INSURANCE COMPANY

In connection with this diagnosis, illness, or accident, have you made a claim, or are you making a claim against any other insurance company or benefit plan? ☐ Yes ☐ No

Name of company		Policy number	

3. PREFERRED METHOD OF REIMBURSEMENT (PLEASE √)

☐ Please send a check

☐ Please transfer the reimbursement to my bank account in the USA

☐ Please transfer the reimbursement to my bank account outside the USA

4. BANK ACCOUNT INFORMATION

Account holder			
☐ Checking ☐ Savings		Account number	
Name of beneficiary bank		ABA number (ACH transfers)	For banks in the USA only
Branch number		SWIFT code	For banks outside the USA
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	

5. PATIENT INFORMATION

Full name	Last name / First name / M.I.	DOB	MM / DD / YY
Gender: ☐ M ☐ F		Relation to policyholder: ☐ Self ☐ Spouse ☐ Child	

6. DETAILS OF DIAGNOSIS, ILLNESS, OR ACCIDENT

Is this claim resulting from an accident? ☐ Yes ☐ No			
If Yes, was the injury caused by the act or omission of a person other than then patient? ☐ Yes ☐ No			
Place of accident ☐ Auto ☐ Home ☐ Work ☐ Other:			
Diagnosis, nature of illness, or type of accident			
Date of first symptom or accident	MM / DD / YY	Date of first consultation for this diagnosis, illness, or accident	MM / DD / YY
Have similar symptoms occurred previously? ☐ Yes ☐ No		When?	MM / DD / YY

7. IN CASE OF HOSPITALIZATION

Name of hospital			Tax ID number	
Address				
Period of hospitalization	From	MM / DD / YY	To	MM / DD / YY

8. TO BE COMPLETED BY TREATING PHYSICIAN

I certify that the information provided in sections 6 and 7 is complete and correct to the best of my knowledge.

Name of treating physician		Tax ID number	
Address			
Signature and stamp		Date	MM / DD / YY
		Registration/ license number	
E-mail		Telephone	

9. OTHER PROVIDERS

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

10. DETAILS OF THE SERVICE PROVIDED

Date of service	Service provider	Description of service	Currency	Charges
MM / DD / YY				
MM / DD / YY				
MM / DD / YY				
MM / DD / YY				
MM / DD / YY				
MM / DD / YY				
MM / DD / YY				
Total charges				
Amount paid by the insured				
Amount paid by other insurance				
Balance due to provider				

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.

The insurer, USA Medical Services, and/or any of their applicable related subsidiaries and affiliates will not engage in any transactions with any parties or in any countries where otherwise prohibited by the laws in the United States of America. Please contact USA Medical Services for more information about this restriction.

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

AUTHORIZATION FOR PROVIDERS TO RELEASE HEALTH INFORMATION

Bupa Insurance Company and its Miami subsidiaries and affiliates (collectively "Bupa") may need to use my and/or my dependents' protected health information including, without limitation, my and/or my dependents' medical records/history, 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, including any member of my family having access to any medical records or knowledge of myself or my health, to disclose such information to Bupa, its Business Associates, or its designated agents (collectively, "Bupa Entities"), 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 and subject to and in accordance with 45 C.F.R. §164.508. 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.

Policyholder's signature		Date	MM / DD / YY
Patient's signature (if 18 or older)		Date	MM / DD / YY