Accident & Sickness Medical Claim Form

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

Claims & Legal Services
Adventist Risk Management
12501 Old Columbia Pike
Silver Spring, MD 20904

Phone (301) 680-6865 / (301) 680-6867
Fax (301) 680-6878
E-mail: claims@adventistrisk.org

Please complete Sections A, B and C. 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. Attach bills and/ or receipts and return to the address listed above. Please note that you may scan and email or fax claims.

SECTION A INSURED / PATIENT INFORMATION SEÇÃO A INFORMAÇÃO SEGURADO / PACIENTE

Name of Group Nome do grupo	Policy Number Número da apólice
Insured's Name Nome do segurado	Insured's Date of Birth Data de nascimento do segurado
Patient's Name Nome do paciente	Patient's Date of Birth Data de nascimento do paciente
Home Address Endereço	

Please provide telephone and facsimile numbers, with country and city codes. coloque os códigos do telefone

Home Phone Number Telefone residencial	Work Phone Number Telefone do trabalho	Fax Number	E-mail Address e-mail
Manager's Name Nome do gerente	Work Phone Number Telefone do trabalho	Fax Number	E-mail Address e-mail

SECTION B TRAVEL INFORMATION *Please complete this section* SEÇÃO B INFORMAÇÃO DA VIAGEM

My Business location is in (country of employment)	Meu local de trabalho (país
I / we left the above country on (Day / Month / Year)	Eu/nós saimos do país acima no dia/mês/ano
I / we visited the following countries	Eu/nós visitamos os seguintes países
I / we are expected to return home on (Day / Month / Year)	Eu/nós pensamos retornar para casa em dia/mes/ano
The purpose of my / our trip was	O propósito da minha/nossa viagem foi

SECTION C PAYMENT INFORMATION Please complete Option #1, #2 or #3 SEÇÃO C INFORMAÇÃO DE PAGAMENTO

☐ OPTION #1 - **Payment to INSURED** OPÇÃO 1 - Pagamento para o segurado

Please indicate where you wish the payment to be sent and in what currency.

☐ **Your home address as listed above** Enviar para seu endereço ☐ **Direct deposit to your bank account** Depósito direto na sua conta

Name on account: Nome na conta	Account #: Conta
Bank Name: Nome do banco	Swift Code: Código Swift
Bank Address: Endereço do banco	Currency: Moeda
IBAN:	

☐ OPTION #2 - **Payment to a Provider, e.g. hospital, physician**

Please complete Provider's name and address in Section E of this Claim Form

OPÇÃO 2 pagamento para o hospital, médico, etc.

☐ OPTION #3 - **Payment to the Employer** OPÇÃO 3 - pagamento para o empregador

Employer's Name: Nome do empregador

Employer's Address: Endereço do empregador

Autorização de pagamento: Eu autorizo o pagamento diretamente para mim, meu empregador ou hospital

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

INSURED'S SIGNATURE ASSINATURA DO SEGURADO **DATE** DATA

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 ASSINATURA DO PACIENTE **DATE** DATA

SECTION D OTHER COVERAGE INFORMATION SEÇÃO D INFORMAÇÃO DE OUTRA COBERTURA

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 Tem outro seguro? If yes, please provide source of insurance. Se si, por favor diga que seguro.

Is this claim accident related? ☐ Yes ☐ No Sinistro relacionado a acidente? Is this claim worked related? Sinistro relacionado ao trabalho? ☐ Yes ☐ No

If yes, please provide documents relating to accident or work injury. Se sim, enviar documentos sobre o acidente.

If claim is due to an accident, are you seeking reimbursement from another source? ☐ Yes ☐ No Se por acidente, busca reembolso de outra forma? If yes, please provide source of insurance.

Spouse's name Nome do cônjuge	Spouse's insurance company Compania de seguro do cônjuge
Spouse's employer and telephone # Empregador do côjuge e telefone	
Dependent's date of birth Data de nascimento do dependente	Is your dependent a full-time student? ☐ Yes ☐ No Estudante tempo completo? *If yes, please provide documentation of current academic registration.*

SECTION E PHYSICIAN OR PROVIDER *Please complete this section.* SEÇÃO E MÉDICO OU PROVEDOR

Name of physician or provider of service	Nome do médico ou provedor do serviço
Address	Endereço
Telephone #	Telefone
Diagnosis or nature of illness or injury	Diagnóstico ou natureza da doença ou lesão

Date of illness (first symptom) or injury Data da doença (1° sintoma) ou lesão	Date first consulted for this condition Data da 1ª consulta para esta condição
Hospital confinement dates: From To Data de internação	Date able to return to work Data alta para retorno ao trabalho
Total disability dates: From Data de incapacidade To	Partial disability dates: From To Data de incapacidade parcial
Patient's account # Conta do paciente	Amount paid Valor pago / Balance due balanço de conta
Place of service Lugar de trabalho	Diagnosis code and description Código de dignóstico e descrição

Date of Service	Procedure code and description/ Predetermination of benefits	Charges	Total charges
Data do serviço	Código de procedimento Predeterminação de beneficios	Cobranças	Total geral

AUTORIZAÇÃO e DESTINO DOS BENEFICIOS

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
Assinatura do Segurado ou Representante Autorizado	Relação com o segurado	Data

Address: Endereço

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 to 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: Any 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.