

**INFORMATION**

**To be considered, claim form and receipts for expenses must be submitted within 90 days of the date of service.**

- This form must be completed and signed by the claimant in its totality.
- Detailed description of all services received and of all expenses
- Detailed invoices of all expenses must include the name of the treated person; type of illness or injury must be attached

**Send claims to:**

Claria Life and Health 7491 W. Oakland Park Boulevard 2nd. floor. Tamarac, Florida 33319  
Phone: (954)749-1025 Fax: (954)749-1027 Email: medical@claria.us

**PATIENT INFORMATION**

Name of primary insured

Gender:

Effective date

Policy number:

Date of birth:

Name of patient:

Relation to primary insured:

Date of birth:

Gender:

Address:

Are you insured by another company?

Policy number:

Name of insurance company:

**DETAILS**

**PART 1: ILLNESS OR DISORDER**

1. Diagnosis:

2. Have you been treated for disease before?

3. Details of when and where the first symptoms occurred:

**PART 2: ACCIDENT OR INJURY**

1. Date and place of the accident or injury:

2. Where the injuries caused by an automobile accident?

3. Did the incident occur while working?

4. Details of how accident occurred:

5. Other:

**PART 3: MATERNITY**

1. Probable delivery date:

2. Any complications with the pregnancy or delivery?

3. Have you undergone any fertility treatment?

**PART 4: ADDITIONAL INFORMATION**

1. Name and telephone number of primary physician:

2. Name and telephone number of treating physician:

3. Provide name of prescription drugs being taken if any:

4. Are you under observation, treatment or referred to a physician for the condition above (please detail):

**AUTHORIZATION**

**I authorize** any hospital, medical institution, physician, insurance company, pharmacy, insurance support organization, government agency, employer, union, family member or administrator of any benefit policy to provide all the information required to Claria Life and Health Insurance Company regarding medical history, outpatient treatment and any treatment received, injuries or illness suffered. **I understand** that this authorization will be valid for the term of coverage of the policy above identified and copy of this authorization will be considered as valid as the original. **I will provide** Claria Life and Health Insurance Company any information concerning my medical history in order to process the claim. **I understand** that if I fail to provide the required documents this could cause the claim to be voided or denied. **I certify** that the information provided is accurate and truthful to the best of my abilities and understanding. I also understand that any false or omitted statement in this claim form could result in the rejection of this claim. **I also understand** that I or any person acting on my behalf can receive a copy of the authorization

\_\_\_\_\_  
Signature of Claimant or representative (if minor)

\_\_\_\_\_  
Day/Month/Year



Life and Health Insurance Company

**AUTHORIZATION TO PROVIDE RESTRICTED HEALTH INFORMATION TO : CLARIA LIFE AND HEALTH INSURANCE COMPANY**

I authorize any hospital, medical institution, physician, insurance company, pharmacy, insurance support organization, government agency, employer, or another healthcare provider that has provided payment, treatment or service on my behalf in the past to divulge my complete medical history and all the information required that might be considered restricted under the "Health Insurance Portability and Accountability Act of 1996"(HIPPA) referring to my insurance company, its employees and representatives.

I understand that the information in my medical history could include information concerning sexually transmitted diseases, the Acquired immune deficiency syndrome (AIDS) or the Human immunodeficiency virus (HIV). Could also include information about medical assistance for mental and behavioral, as well as for the drugs or alcohol abuse.

With my signature below, I terminate any agreement that I have with my providers to restrict mi medical history and any information associated with my health and I request my providers to send my medical history in its totality and without any restrictions.

This protected information must be disclosed under this authorization in a way in which the insurance company: 1) subscribe my application for coverage, determine eligibility, revise the risk level, underwrite a policy and the determinations of inscription; 2) obtain the reassurance; 3) administrate incidents and determine or satisfy the coverage and dispositions of the benefits; and/or 4) administrate the coverage with the insurance company.

I understand, that I have the right to revoke this authorization at any moment unless at the moment of cancelation the authorization has been already used to acquire and obtain the information. I understand that a revocation will not be effective if any of my providers has relied on this authorization or to the extent that the insurance company has legal right to contest a claim under and insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization may be re-disclosed and no longer covered by certain federal rules governing privacy and confidentiality of health information. This authorization shall remain in force for 24 months following the date of my signature below, and a copy of this authorization is as valid as the original.

I understand that my providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization. I also understand that if I refuse to sign the authorization, the insurance company may not be able to process my application, or if coverage has been issued may not be able to make any benefit payments. I acknowledge that I have received a copy of this authorization.

The information to be used or disclosed will include but is not limited to:

- |  |  |
|--|--|
| <input checked="" type="checkbox"/> Physical Exams and History         | <input checked="" type="checkbox"/> Admission notes            |
| <input checked="" type="checkbox"/> Imaging reports and X-rays         | <input checked="" type="checkbox"/> Medical orders             |
| <input checked="" type="checkbox"/> Results for lab tests              | <input checked="" type="checkbox"/> Nurses notes               |
| <input checked="" type="checkbox"/> Reports from medical consultations | <input checked="" type="checkbox"/> Complete medical history   |
| <input checked="" type="checkbox"/> Procedure and surgery reports      | <input checked="" type="checkbox"/> Discharge Summary          |
| <input checked="" type="checkbox"/> Cardiovascular exams               | <input checked="" type="checkbox"/> List of prescription drugs |
| <input checked="" type="checkbox"/> Emergency room history             | <input checked="" type="checkbox"/> Progress notes             |

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Social security number / ID: \_\_\_\_\_

\_\_\_\_\_  
Signature of Patient or Legal Guardian

\_\_\_\_\_  
Relation to Patient

Signed on date: \_\_\_\_\_

