PRE-NOTIFICATION FORM

INFORMATION

Entire form must be completed and submited by fax or e-mail.

Send to: Claria Life and Health Insurance Company 801 NE 167th Street, 2nd Floor North Miami Beach, FL 33162

Phone: (305)493-3071 Fax: (305)493-3078 Email: medical@claria.us

Please note: this is not a guarantee of payment

GENERAL INFORMATION

Main insured Name: _____ Main Insured Last name: _____

Notifier's Name: _____

Time: _____ Date: _____

Patient's Full Name: _____

Gender: _____ Date of birth: _____ Policy Number: _____ Effective date: _____

Telephone: _____ Cell Phone: _____ Fax: _____

PHYSICIAN AND HOSPITAL INFORMATION

Primary/Referring Physician's Name: _____

Telephone: _____ Email: _____

Treating Physician's Name: _____

Telephone: _____ Email _____

Hospital / Clinic: _____

Telephone: _____ Email: _____

PROCEDURE / SURGERY INFORMATION

Procedure / Surgery: _____

Date of Service: _____ Date of Diagnosis: _____

Diagnosis (Please attach avalaible reports): _____

Surgeon Fees (Please attach if avalaible): _____

Hospitalized ◯ Outpatient ◯ Amount of days hospitalized if it applies: _____

Pre-Notification issue date: _____

_____ _____

Signature of Claimant or representative (if minor) Day/Month/Year