CLAIM FORM

INFORMATION

To be considered, claim form, medical records and original itemized 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 entirety.
- Include a detailed description of all services received and of all expenses
- Detailed original 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 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

PATIENT INFORMATION

Name of primary insured _____

Gender: _____ Effective Date: _____ Policy Number: _____ Date of Birth: _____

Name of patient: _____ Telephone number: _____

Relation to primary insured: _____ Date of birth: _____ Gender: _____

Address: _____ Email: _____

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 this 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. Were 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. State the 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 _____

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 my 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-diclosed 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:

- √ Physical Exams and History
- √ Imaging reports and X-rays
- √ Results for lab tests
- √ Reports from medical consultations
- √ Procedure and surgery reports
- √ Cardiovascular exams
- √ Emergency room history
- √ Admission notes
- √ Medical orders
- √ Nurses notes
- √ Complete medical history
- √ Discharge Summary
- √ List of prescription drugs
- √ Progress notes

☐ Patient Name: _____

Date of Birth: _____ Social security number / ID: _____

Signed on date (DD/MM/YYYY): _____

_____ Signature of Patient or Legal Guardian

_____ Relation to Patient