Health Insurance
Claim Form

Internacional de Seguros

Company with whom you have the Policy: _____

Policyholder's Name: _____

Email: _____ **Phone:** _____

Name of the person receiving the service: _____ **Identification N°:** _____ **Age:** _____

Name of Treating Physician: _____ **Phone:** _____

SECTION I: To be completed by the Policyholder or Claimant

Type of condition: Accident ☐ Illness ☐ Pregnancy ☐ Other ☐ Date of onset of illness/accident/pregnancy: _____

Describe symptoms/event: _____

Service Claimed: Medications ☐ Medical Consultation ☐ Laboratories ☐ Procedure/Surgery ☐

Imaging ☐ Special Studies ☐ Medical Check Up ☐ Other: _____

I hereby certify that the foregoing answers and the attached invoices are true and accurate to the best of my knowledge and belief. I authorize all physicians and other persons who treated me and all hospitals and other institutions to provide the Insurance Company covered by this policy with any information, including accurate copies of their records and test results pertaining to this claim. It is understood that the Insurance Company reserves the right to defer settlement of this claim until all evidence necessary for settlement has been obtained and to its complete satisfaction.

Date: _____ **Policyholder's signature:** _____

Remember to attach invoices for all services received, as well as statements of Hospital expenses, medical fees (surgeon, anesthesiologist, assistant, others), study request orders with their respective reports or results (laboratories, images, others) and prescriptions for medications prescribed by your treating physician.

SECTION II: To be completed by the Treating Physician or Provider

Patient's Name: _____ **Age:** _____

Type of condition: Accident ☐ Illness ☐ Pregnancy ☐ Other ☐ Date of onset of illness/accident/pregnancy: _____

Diagnosis/Diagnostic Impression/Symptoms (Detail):

IN THE EVENT OF AN ACCIDENT

Describe the trauma mechanism:

_____

_____

IN CASE OF MATERNITY

LMP: _____ Weeks of Gestation: _____ Labor/Abortion Date:

_____

_____

IN CASE OF VISION BENEFIT: (Applies if the policy has contracted the benefit and under the conditions stipulated in the insurance contract).

Diagnosis: _____ Lens Prescription: **OD** _____ **OS** _____

Note: As attending Physician, I authorize hospitals and other institutions to provide the Insurance Company covered by this policy with all reports concerning the health of the insured patient, including all data on past illnesses. To this effect, in this case, I release the institutions or persons involved from professional secrecy and I state for the record that a copy of this authorization has the original value. Under oath, I declare that the information provided in this form was taken directly from both the insured patient and the clinical record.

Physician's Signature and Medical Code: _____ **Stamp:** _____ **Date:** _____

THE INSURANCE COMPANY will reimburse the medical fees charged, based on the individual conditions of the contracted policy. In no case will expenses that are not reasonably necessary be recognized as covered expenses, nor will any be paid in excess of the amount that should USUALLY be recognized for the service or drug in question.

The contractual documentation and the technical note that compose this product are registered before the General Insurance Superintendence in accordance with the provisions of Article 29, paragraph d) of the Insurance Market Regulatory Law No. 8653, under registration No. P20-64-A07-399, dated January 17, 2013.