



Attending Physician's Statement Claim Form

Travel Insured International; Claims Department. P.O. Box 280568, East Hartford, CT 06128;
p: 800.243.2440 (in U.S. & Canada); p: 1.860.528.7663 (outside U.S.) f: 860.528.8005;
Email: claims@travelinsured.com; www.travelinsured.com



Please complete the following form with information pertaining to the most recent onset of the illness. Please print clearly.

Patient's Name (First, Middle, Last)	Planholder	Plan/Policy No.
Diagnosis and/or ICD-9 Code		
What is the exact date the symptoms first appeared?		When did the patient first consult you for this condition?
Did you advise the trip be cancelled or interrupted due to the patient's medical condition? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain why.		
Has the patient ever had the same or similar condition? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, what was the date?
Is this condition a complication of an underlying condition? <input type="checkbox"/> Yes <input type="checkbox"/> No	List all dates you provided treatment for this condition.	
Was this patient referred to you by another physician? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what was the date referred?		
Name of Physician	Phone #	If the patient was hospitalized, provide name of hospital.
Was this an emergency room admission? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date admitted	Date discharged

Please note: All of the above requested information is necessary for the processing of the planholder's claim. Any omitted items will delay processing.

Physician's Name	Physician's Employer ID#	
Physician's Specialty	Phone #	Fax #

Any person who knowingly and with intent to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information may be guilty of a criminal act punishable by law.

I have read the foregoing, and the above answers are true and complete according to the best of my knowledge and belief.

_____/_____/_____
Signature of **Physician** **Date**



Planholder/Patient Statement Claim Form

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To Planholder: Please complete and have patient sign authorization below

Patient's Name (First, Middle, Last)	Date of Birth	Planholder's Name	Plan/Policy #
Was the patient scheduled to go on a trip? (Trip activities, cruise, flight, hiking, etc.)		Destination	Departure date
Provide name and address of your regular physician in his/her home country:		Phone #	Fax #
Please list names of any prescription medications presently taken:			
Indicate other health insurance coverage, include name, address and policy #:			
If injury is a result of an accident please give a detailed explanation.			
Involving a motor vehicle? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please list the names of the involved parties, insurance carriers and policy numbers.			
Was a police report files? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please identify the Police Department where it was filed.			

Authorization to obtain and disclose information in connection with a claim for benefits:

TO: ALL PROVIDERS OF MEDICAL OR DENTAL SERVICES OR SUPPLIERS AND THEIR REPRESENTATIVES, ALL INSURERS, MEDICAL OR HOSPITAL SERVICE PLANS, PREPAID HEALTH PLANS, EMPLOYERS, GROUP POLICYHOLDERS OR CONTRACT HOLDERS. FOR PURPOSES OF CLAIMS ADMINISTRATION AND AUDIT, I AUTHORIZE YOU TO FURNISH TRAVEL INSURED INTERNATIONAL, INC., OR IT'S REPRESENTATIVES PERFORMING BUSINESS OR LEGAL FUNCTIONS, ANY INFORMATION AVAILABLE ABOUT THE MEDICAL HISTORY, CONDITION AND TREATMENT OF, 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 TRAVEL INSURED INTERNATIONAL, INC. TO USE SUCH INFORMATION AND TO REDISCLOSE IT FOR THE ABOVE PURPOSES TO ITS REPRESENTATIVES, AND TO MY EMPLOYER, UNION, GROUP CONTRACT HOLDER AND THEIR REPRESENTATIVES, AND TO ANY INSURER, MEDICAL OR HOSPITAL SERVICE PLAN, PREPAID HEALTH PLAN OR REINSURER. I ALSO AUTHORIZE TRAVEL INSURED INTERNATIONAL, INC. TO REDISCLOSE SUCH INFORMATION TO AN ATTENDING PHYSICIAN FOR TREATMENT PURPOSES, TO GOVERNMENTAL AUTHORITIES WHEN NECESSARY TO PREVENT OR PROSECUTE FRAUD OR OTHER ILLEGAL ACTIVITIES, TO ANY PERSON WHO HAS AN AUTHORIZATION SPECIFICALLY PERMITTING THE REDISCLOSURE, AND AS MAY BE PERMITTED OR REQUIRED BY LAW.

THIS AUTHORIZATION IS VALID FOR ONE YEAR FROM THE DATE BELOW. I AGREE THAT A PHOTOGRAPHIC COPY OF THIS AUTHORIZATION SHALL BE VALID AS THE ORIGINAL. I KNOW THAT I HAVE THE RIGHT TO ASK FOR AND RECEIVE A COPY OF THIS AUTHORIZATION.

Signature of **Patient**
(Parent if minor)

Date