

# Health Claim Form



**INTERNATIONAL**

*A division of Morgan White Group*

75 Valencia Ave, Suite 801  
Coral Gables, FL 33134

## Part I: Primary Insured Information

To expedite the claim process, please include proof of payment, medical bill(s) and pertinent medical information. If additional medical information is required, the administrator will request it directly from your doctor.

Last name	First name	I.
Customer number	Email address	Phone (Home/Cell)
Address	DOB Day/Month/Year	

## Part II: Claimant Information

Last name	First name	I.
DOB Day/Month/Year	Sex Female Male	Relationship to primary insured Self Spouse Child
Customer number	Do you have any other health insurance <i>(If yes, please provide the insurance company information)</i> Yes No	
Name of the insurance company	Address	

## Part III: Accident Related Services

Date of injury or accident (Day/Month/Year)	Did the injury occur while working? Yes No	Is injury due to automobile accident? Yes No
How did injury or accident occur?		

## Part IV: Illness Related Services

Nature of illness	Date first symptoms occurred <i>(Day/Month/Year)</i>	
Name of treating physician	Address of physician	
Are you currently under medical observation, treatment or taking any prescribed drugs? <i>(If yes, please provide name and address of treating physician)</i>	Yes	No
Have you received treatment for the same condition before? <i>(If yes, please provide name and address of treating physician)</i>	Yes	No
Have you received medical treatment of any kind in the past 10 years? <i>(If yes, please provide name and address of treating physician)</i>	Yes	No

I declare the answers to the previous questions are true and complete to the best of my knowledge and belief. I authorize any physician, medical institution, insurance company, employer, labor union or association to release information to MWG International as is required to properly process this claim. A photostatic copy of this authorization shall be considered valid as the original.

Signature of primary insured \_\_\_\_\_ Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
*(If the insured (patient) is under age, the primary insured shall sign on the patient's behalf)* Day Month Year

# Health Claim Form (continued)

To be completed by the treating physician

## Part V: Patient Information

Name of patient		DOB Day/Month/Year	Sex Female      Male
Date on which patient first consulted you (Day/Month/Year)	Date on which first symptom or accident occurred (Day/Month/Year)	Date on which patient first consulted you for symptom (Day/Month/Year)	
Please give your diagnosis of the illness/injury			
Will illness/injury require follow up treatment? (If yes, please provide details)			Yes      No
Has diagnosis and/or treatment for same or any related condition been given previously? (If yes, please provide name and address of treating physician)			Yes      No
Has patient been referred to you by another physician? (If yes, please provide name and address of treating physician)			Yes      No

## Part VI: Maternity Claim

Uterus enlargement measurement	Date of last menstrual period	Time period of pregnancy	
Expected date of delivery	Pregnancy: Multiple      Single      Spontaneous      Assisted		
Date of Services	Describe medical procedure, please describe medical services or supplies furnished for each date given		Charges
Total amount due:			
Amount paid by patient:			
Balance due:			

Treating physician name	Phone
Address	Medical license number

Signature of treating physician \_\_\_\_\_ Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Day      Month      Year

**NOTE:** Return this claim form, with original invoices and receipts, within 180 days of treatment. Dependent children, 18-years-old and over, should include a copy of their school certificate. Complete a separate form for each illness or accident.

If you wish to receive your claim payment by wire transfer, please complete the Wire Transfer Form