Health Claim Form

MWG 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 *(If yes, please provide the insurance company information)* ☐ 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 *(Day/Month/Year)*
Name of treating physician	Address of physician

Are you currently under medical observation, treatment or taking any prescribed drugs? *(If yes, please provide name and address of treating physician)*	☐ Yes ☐ No
Have you received treatment for the same condition before? *(If yes, please provide name and address of treating physician)*	☐ Yes ☐ No
Have you received medical treatment of any kind in the past 10 years? *(If yes, please provide name and address of treating physician)*	☐ 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.

_____ Date _____ / _____ / _____

Signature of primary insured — Day Month Year

(If the insured (patient) is under age, the primary insured shall sign on the patient's behalf)

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

_____ Date _____ / _____ / _____

Signature of treating physician — 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.