Travel Insured INTERNATIONAL

Planholder/Patient Statement Claim Form

TRIP PRESERVER from red sky travel insurance

Travel Insured International, Inc.®
Claims Department, P.O. Box 280568, East Hartford, CT 06128
Phone: 1-866-690-6499 | Fax: 1-860-528-8005
Email: claims@travelinsured.com | Web: www.travelinsured.com

To Planholder: Please complete and have patient sign authorization below

Patient's Name (First, Middle, Last)	Date of Birth	Planholder's Name	Plan/Policy No.
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 advise names of any prescription medications presently taken:

Indicate other Health Insurance coverage, include name, address, and policy number:

Is this condition the result of an accident or illness:

Involving a motor vehicle? ____ Yes ____ No If Yes, please list the names of the involved parties, insurance carriers and policy numbers.

Was a police report filed? ____ Yes ____ 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 CONTRACTHOLDER 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**

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

Patient's Name	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? ____ Yes ____ No If Yes, Please explain why.

Has the patient ever had the same or a similar condition?	If Yes, what was the date?
Is this condition a complication of an underlying condition?	List all dates you provided treatment for this condition.
Was this patient referred to you by another physician? ____ Yes ____ No	If Yes, what was the date referred?

Name of Physician	If Yes, what was the date referred?	Phone #

If the patient was hospitalized, provide name of hospital	Was this an emergency room admission? ____ Yes ____ 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 Speciality	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**