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MEDICAL CLAIM FORM

PRINCIPAL'S STATEMENT

(**Note**: **ALL questions MUST be answered for every claim**.
NA = Not Applicable)

Principal's RAN:_____ Plan Code:_____ Group Name:_____ Group Number:_____ Submit Date: **D M Y**

1. Principal's Name _____ Date of Birth D M Y. Sex: Female ☐ Male ☐
2. Name of Patient _____ Date of Birth D M Y. Sex: Female ☐ Male ☐
3. Relationship of Patient to Principal: Self ☐ Spouse ☐ Biological Child ☐ Other ☐ (Explain) _____
4. Illness/**Purpose** of Claim _____ Attending Physician _____
5. Current Personal Physician_____ Phone & Address_____
6. Has the claimant familiarized him/herself with the terms and conditions of the contract for this medical plan? Yes ☐ No. ☐
7. What are the patient's most recent **height** and **weight**? **Ft**__**In**___ **Lb**____ or **Cm**____**Kg**____ **Date Taken** D M Y.
8. When did symptoms of this illness first occur? ⇒ ⇒ ⇒ ⇒ D M Y. NA ☐
9. If the patient has any exclusion(s) please state here._____ No ☐
10. Was treatment necessary because the patient was injured or poisoned? ⇒ ⇒ ⇒ Yes. ☐ No ☐
11. If patient was injured or poisoned, state the **Date**, **Time** and **How** the incident occurred. _____ NA ☐
12. Did patient voluntarily participate in an activity that exposed the patient for abuse or endangerment? ⇒ Yes. ☐ No ☐
13. Was attempted suicide a factor in the cause of this illness or condition? ⇒ ⇒ ⇒ Yes. ☐ No ☐
14. Has this illness previously occurred as a pre-existing condition as defined in the Table of Incubation Periods? Yes. ☐ No ☐
15. If you gave 'Yes' to question **14 above** please tick whether the illness was: **(a)** certified cured **(b)** covered ⇒ **(a).** ☐ **(b).** ☐ NA ☐
16. If you answer "Yes" to question **14 above** please give the **Date Of Certification**, or date its coverage began. ⇒ D M Y. NA ☐
17. If certified cured, please give the name of the certifying doctor. _____ NA ☐
18. If certified cured, please give the address of certifying doctor. _____ NA ☐
19. Has the patient ever used **tobacco** or **tobacco products**? ⇒ ⇒ ⇒ Yes. ☐ No ☐
20. If **tobacco** use is currently terminated, please state **Reason**(**R**) and **Date**. **R.**_____ D M Y. NA ☐
21. Had the patient ever been identified as having **Hypertension**? ⇒ ⇒ ⇒ Yes. ☐ No ☐
22. If the patient had been identified as having **Hypertension**, please give date (or year) of diagnosis. ⇒ D M Y. NA ☐
23. Had the patient ever been identified as having **Diabetes**? ⇒ ⇒ ⇒ Yes. ☐ No ☐
24. If the patient had been identified as having **Diabetes**, please give date (or year) of diagnosis. ⇒ D M Y. NA ☐
25. Is patient entitled to **Workmen Compensation** or coverage under any **Other Plan**? ⇒ ⇒ Yes. ☐ No ☐
26. If you gave 'Yes' to question **25 above**, give name of entity._____ NA ☐
27. If you gave 'Yes' to question **25 above**, is the patient entitled to make any claim for the relevant benefits? ⇒ Yes. ☐ No. ☐ NA ☐
28. Does the patient or Principal owe the Company for any current indebtedness? If so state: Balance Unpaid? $_____ No ☐ NA ☐
29. Check all your receipts submitted for this claim and in the spaces provided below please write your total expenses for each category.

A) No. of Days Supply of Prescription Drugs? ⇒ _____Days. Cost $_____ **B**) Days Visited Doctor? _____Days. $_____
C) No. of Days Supply of Non-prescription Drugs? _____Days. Cost $_____ **D**) Days Visited Specialist? _____Days. $_____
E) No. of Days Supply of Room & Board? ⇒ _____Days. Cost $_____ **F**) Hospital Services? ⇒ ⇒ $_____
G) Surgeon's Fee? ⇒ $_____ **H**) Anesthetist's Fee? $_____ **I**) Diagnostics? (X-rays, Labs, Scans, etc) $_____
J)_____? $_____ **K**)_____? $_____ **L**) Discount? ⇒ ⇒ $_____
M) What is the discounted value of the expenses supporting your claim for which you have submitted the receipts listed above? $_____

I hereby certify that the forgoing answers are true and correct to the best of my knowledge **and understand and accept that omission or misrepresentation of any material fact shall constitute a breach of contract.** I accept that all incidental costs to support this claim are for my account and that only original documents are valid in support of my claim and that once submitted, all documents associated with the loss, becomes the property of the Company. I hereby authorize all doctors or other persons who treated me and all hospitals or other institutions to furnish full information (including full copies of their records) to MEDISERV INTERNATIONAL Ltd. (the Company) or its assigns.

Date_____ Principal's Signature X_____ Patient's Signature (if over 18yrs) X_____

APPLICATION FOR ASSIGNMENT OF COVERAGE BENEFITS NA ☐

I hereby authorize MEDISERV INTERNATIONAL Ltd. to pay to _____ whatever benefits to which I may be entitled with respect to the services rendered to the named patient from D M Y to; D M Y
All ineligible charges shall be borne by me.

D M Y
Date

X_____
Principal's Signature

NA. ☐

FOR OFFICIAL USE ONLY

D M Y
Date Received

_____
Recipient's Name (PRINT)

X_____
Group Administrator's Signature

_____
Title

Notes: Where there is not enough space, you may sign another form or your own paper to complete your response. Please ensure that your doctor completes all questions on the reverse side, especially the section named **"MEDICAL FACTORS."** This can eliminate delays, inconvenience and the expense of obtaining some additional reports.

ATTENDING PHYSICIAN'S STATEMENT

Note: The patient and or claimant seek your impartial professional input to fulfill obligations associated with this claim. Please fill this form completely and accurately. Unless stated in writing by the Company, no commercial, professional, administrative and or any substantive relationships and or obligations with the patient and or claimant are shared with, or transferred to the Company; and should not be assumed by the mere presentment and or completion of this document.

A) (**i**) Name of patient: _____ Date of Birth: D M Y . (**ii**) Name of Principal/Claimant: _____

B) Doctor's or Institution's **Name**, **Address** and **Contact Information**: (*A stamp, legibly applied anywhere, will suffice*): _____

DOCTOR' S VISITS	(**A**) DATE OF VISIT OR SERVICE **Day | Mth | Yr**	(**B**) DIAGNOSIS (DESCRIBE COMPLICATIONS IF ANY)	(**C**) TYPE OF VISIT (OFFICE, HOME OR HOSPITAL)	(**D**) VISIT FEE	(**E**) NAME OF DRUG(S) PRESCRIBED OR INJECTED	(**F**) QTY.	(**G**) COST (IF SUPPLIED)	(**H**) OTHER SERVICE RENDERED (SPECIFY)	(**I**) COST $	(**J**) FURTHER SERVICE RECOMMENDED	(**K**) DOCTOR'S SIGNATURE ⇓ ⇓

SURGICAL OPERATION

(**i**) Please describe procedure(s) performed: (**ii**) Date of Surgery: D M Y . (**iii**) Surgeon's Fee: $_____

(**iv**) Anesthetist's Fee: $_____

MATERNITY

A. **(i)** Date of Conception: D M Y . **(ii)** Date of Delivery or Termination: D M Y . **(iii)** Obstetrician's Fee: $_____

B. Was: **(i)** Artificial Insemination, **(ii)** Fertility Drugs, **(iii)** Hormone Treatment or **(iv)** Other means induce pregnancy where medical or other assistance used? Yes. ☐(_____) No ☐

C. Type of Delivery/Procedure? **(i)** Normal ☐ **(ii)** Caesarian Section ☐ **(iii)** Miscarriage ☐ **(iv)** D&C ☐ **(v)** Other ☐ _____

D. Reason Delivery/Procedure not Normal? _____

MEDICAL FACTORS

Please complete, date and sign this section to ensure that patient's claim is not delayed.

*(You may wish to review the "**Note**" section on top of this page.)*

A. Has patient been satisfactorily pursuing your: **(i) Appointments** Yes ☐ No ☐ NA ☐ **(ii) Treatment** Yes ☐ No ☐ NA ☐ **(ii) Advice** Yes ☐ No ☐ NA ☐ (*NA = Not Applicable*)

B. Has the patient been identified as: **(i) Hypertensive** Yes ☐ No ☐ **(ii) Diabetic** Yes ☐ No ☐ **(iii) Tobacco User** Yes ☐ No ☐

C. Please identify any factors that may have: **(i) Aggravated**☐ the illness or condition, and or **(ii) Hindered**☐ recovery? _____

_____

D. Please state what, in your professional opinion, is the **underlying cause** of this illness or condition? _____

_____

E. Please use the Class Numbering System below to classify the illness or condition by describing its underlying cause.
Encircle all relevant Class Numbers including only any descriptions that apply. *(Example: A contagious disease, Gonorrhea, has an incubation less than 3 months, i.e., Class 2; it is also a venereal disease, i.e., Class 6; and it is also generally accepted as curable, i.e. Class 10. Though it may affect organs, it is **NOT** classified with organs, i.e., Class 7)*

Class No.	Description
1.	Physical Injury from external force; Poison
2.	Infectious; Contagious; Parasitic (incubation **less than** 3 months)
4.	Infectious; Contagious; Parasitic (incubation **greater than** 3 months)
6.	Maternity; Congenital; Abortion; Venereal Disease
7.	Chronic; Circulatory; Degenerative; Organ; Gland; Malignant
8.	Psychiatric; Nervous System; Syndrome
9.	Tumor; Cancer; Abnormal Growth; Concretions
10.	Generally accepted as **curable**
11.	Generally accepted as **incurable**
12.	Allergy; Immune Deficiency
13.	Tobacco; Alcohol; Substance Abuse
15.	Nuclear radiation; Of Biological or Chemical Arsenal

Additional Remarks: _____

Date: D M Y Doctor's Signature X _____

We passionately support preventative care practices. We appreciate and thank you for your frank, professional input and other services administered to our member.