Claim Form

Submit via e-mail to healthclaims@bmicos.com within 180 days of Service or Procedure

1. GENERAL INFORMATION

Policy No. | Primary Insured

E-mail | Phone No.: Residence | Cell

Name of **Patient** | **Patient's** Date of Birth

Relationship with Primary Insured: ☐ Spouse ☐ Dependent

Reimbursement Preference (if applicable): ☐ Check ☐ Wire Transfer*

*Please complete Form "Provider and Clients Bank Transfer"

2. CLAIM INFORMATION

Diagnosis / Accident Type | Date of Diagnosis / Accident

Date of Service or Hospitalization

Date of Initial Symptoms | Date of Initial Physician Visit

Have you been treated for this condition before ☐ Yes - Date ☐ No

If Pregnant, Have you undergone any Fertility Treatment? ☐ Yes ☐ No

In case of an Accident, Where did it occur? ☐ Auto ☐ Home ☐ Work ☐ Other

Details of how the Accident occurred (Include Police Report)

In relation to this Diagnosis or Accident, Have you submitted or are you planning to submit a claim with another Insurance Company?

☐ Yes - (Include a copy of the explanation of benefits)
☐ No

3. MEDICAL PROVIDER INFORMATION

Name of **Hospital or Clinic** | Phone No. of **Hospital or Clinic**

City / Country | Name of **Treating Physician**

Phone No. of **Treating Physician** | Name of **Contact** Person

Phone No. of **Contact** Person | Ext. | E-mail of **Contact** Person

4. LIST OF DOCUMENTS PRESENTED

☐ Medical Records with Final Diagnosis ☐ Prescription Drugs with Dosage ☐ Lab Tests Results

☐ Radiology Tests Results ☐ Others (specify)

	Currency	Amount/Charges
☐ Hospital and/or Clinic Bills		
☐ Physician's Bills		
☐ Pharmacy Bills (Specify Medications)		
☐ Lab Tests Bills		
☐ Radiology Tests Bills		
☐ Bills - Others (Specify)		
TOTAL CHARGES:		

5. DECLARATION

I certify that the above answers are true and complete to the best of my knowledge and belief. I authorize any physician, medical institution, pharmacist, insurance company, employer or association to release information to BMI Services, Inc. as required to properly pay all benefits, if any, due to me for this claim. A copy of this authorization shall be considered as valid as the original.

Date

Signature of Primary Insured

Signature of Patient

COMMENTS