Claim Form

Redbridge

FOR OFFICE USE ONLY			
Claim No.			
CO-INSURANCE		DEDUCTIBLE	

I-PRINCIPAL INSURED NFORMATION

Full Name:	Jane Smith (Name(s) / Last Name)		Policy Number: 645031713	Date of Birth (MM/DD/YYYY): 09 / 10 / 1980
Residential Address:	Calle Jesus No. 11 (Street)	San Miguel de Allende, GTO (City / State)	Mexico (Country)	37700 (Zip Code)
Email Address:	janesmith@fakeemail.com	Residential Telephone: 415.123.4567	Cellular Number: 415.123.4567	

II-PATIENT INFORMATION (If different than Principal Insured)

Full Name:	John Smith (Name(s) / Last Name)			Date of Birth (MM/DD/YYYY): 10 / 09 / 1980
Residential Address: (if different than the Principal Insured)	Same as above (Street)	City	State	Country / Zip Code
Email Address:	johnsmith@fakeemail.com	Residential Telephone: 415.765.4321	Celullar Number: 415.765.4321	
Full Name of the Primary Physician and Specialty (Internist, Pediatrician, Gynecologist, etc.)	Dr. Jose Gonzalez - Urologist			

III- ADDITIONAL INSURANGE COVERAGE

Does the patient have other health insurance or similar policy in force?	[ ] Yes	[x] No
Has the patient requested, or will request reimbursement of expenses for this event thru another insurance company, entity or plan?	[ ] Yes	[x] No

Amount of reimbursement requested: :	Name of insurance company, entity or plan:	Policy Number:

IV-PHYSICIAN INFORMATION

Full Name:	Dr. Jose Gonzalez (Name(s) / Last Name)		Specialty:	Urologist
Address:	Revolucion 456 (Street)	Queretaro / QRO (City / State)	Mexico (Country)	45678 (Zip Code)
Email Address:	dr.jose.gonzalez@fakeemail.com	Telephone: 442.789.4561	Fax:	

V- CASE DATA

Event Type: [ ] Illness [x] Treatment [ ] Accident [ ] Maternity [ ] Hospitalization [x] Other: Consultation

Diagnosis or Symptoms:	Description of the treatment, procedure or surgery:	Date of Service (MM/DD/YYYY): 12 / 01 / 2020
Kidney stone	Prescribed medication to ease passing of stone	

Place were services were rendered to the patient: [x] Doctor's Office [ ] Laboratory [ ] Emergency Room [ ] Hospital [ ] Other: _____

Name of Hospital or Clinic:	Address:	Telephone Number:

VI- IN CASE OF ILLNESS

Has the patient previously suffered from this condition, or has experienced similar symptoms?	[ ] Yes	[ ] No	Date of First Symptom (MM/DD/YYYY): / /
Has this patient previously required medical attention, or has been hospitalized for this condition or as result of?	[ ] Yes	[ ] No	

VII- PHYSICIAN STATEMENT (if have completed this form)

I hereby certify that the information provided in this claim form is accurate and complete. *Note that this section isn't necessary

Physician's Signature	Medical License Number	Date (MM/DD/YYYY)
		/ /

VIII- SERVICES AND COSTS (*)

Provide detailed cost and services (* original invoices must be submitted with this form)

Date of Service (MM/DD/YYYY)	Procedure Code	Provide description of services, treatment and procedures performed by date	Service Provider Name	Charges
12/ 01/ 2020		**Office consultation with doctor**	**Dr. Jose Gonzalez**	**1500 pesos**
12/ 01/ 2020		**Medication**	**Farmacia GDL**	**443.30**
12/ 01/ 2020		**Urine Test**	**Chopo Lab**	**3500**
12/ 01/ 2020		**Follow up consult**	**Dr. Jose Gonzalez**	**1000**
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Issue Payment to: ☑ Principal Insured ☐ Service Provider (Specify Provider name): **Pay off deductible; see below for reimbursement method**

IX- PAYMENT DETAILS

Preferred Payment Method:	☐ Check ☑ Bank Transfer
Type of Account:	☑ Checking ☐ Saving
Accountholder Full Name:	**Jane Smith**
Beneficiary's Address Registered in Account:	**Calle Jesus No. 11, San Miguel de Allende, GTO, Mexico, 37700**
Account Number:	1 2 3 4 5 6 7 8 9 0
Beneficiary's Bank Name:	Transferwise
BIC / SWIFT (Beneficiary Bank out of USA):	1 2 3 4 5 6 7 8 9 0
ABA / Routing # (Beneficiary Bank if in USA):	1 2 3 4 5 6 7 8 9 0
Intermediary Bank (if it applies):	
Accountholder Signature:	Jane Smith
Date:	**December 1, 2020**

X- PRINCIPAL INSURED AND PATIENT'S DECLARATION

With my signature below, I hereby AUTHORIZE any person or entity, physician, medical practitioner, hospital, clinics, any other medical facility, any staff member or professional staff, insurers and reinsurers, the Medical Information Bureau (MIB) or a similar organization, having information about myself, to provide all my Clinical Records, including drug or alcohol abuse, to the Company for evaluation of the claim herein presented, being aware that Redbridge ensures the confidentiality of my data.

Also, I DECLARE that all information provided in this form is true, complete and free of any misrepresentation or omission of material facts.

Jane Smith	12/ 01/ 2020	Jane Smith	Jane Smith
Principal Insured Full Name (Print)	Date (MM/DD/YYYY)	Principal Insured Signature	Patient Signature (if different than the Principal Insured))

Redbridge
Insurance Company, Ltd.

Claim Form

INSTRUCTIONS TO PROCESS AND SUBMIT A CLAIM

To file a claim for reimbursement, complete and send a Claim Form with all corresponding documents attached, within the first 180 days from date of service.

Original invoices and required documents must be sent to:

Redbridge Network & Healthcare
P.O. Box 144490, Coral Gables, FL 33114 USA

To start the registration and processing of a claim, you must:

- Hand over all documents to your representative; or
- Send legible documents in electronic format, preferably PDF, to: **riclclaims@redbridge.cc**;;
- For questions regarding your claim status, write us to: **claimstatus@redbridge.cc.**

For Client Service, contact us thru:

Collect: 786-345-1769 **| USA/Canada:** 877-244-9167 **| Venezuela:** 5821-2335-7469 **| Peru** 511-706-8442

service@redbridge.cc **| Fax: (305) 232-8881 |** www.redbridgeinsurance.com

REQUIRED DOCUMENTS TO BE SUBMITTED:

Send the original Invoices and legible documents along with the Claim Form, duly completed and signed.

- Invoice from the attending physician(s), specialist or surgeon clearly indicating:
  - Patient's Name
  - Date of Treatment
  - Diagnosis and Procedure
  - Amount Paid
  - Physician's signature, specialty and medical license number
- Medications receipts and copy of prescriptions (whose validity does not exceed 6 months), indicating if they are for continue use or not
- Laboratory invoices, must include in detail all tests performed, and their results
- Invoice and results of diagnostic test, radiology, and magnetic resonance imaging (MRI), etc.
- **In case of Special Treatments or Therapy**, include the amount of services
- **In case of a Hospitalization or Surgery,** also include:
  - Medical report – diagnosis related with the hospitalization or surgery
  - Detailed invoice of the expenses incurred, and evidence of payment made
  - Copy of the hospital Epicrisis and discharge report
  - Medical notes for all days of hospitalization, including reports from the operating room and anesthesia.
  - Laboratory test results or other diagnostic test readings
  - Pathology report in case of a biopsy
- **In case of Accident**, also include:
  - Police report or affidavit describing the accident, date, place and time
  - In case of a Vehicle Accident:
    - Police report
    - Adjuster's report from the insurance company covering the vehicle
- **In case of Coordination of Benefits**, also include:
  - Copy of all invoices related with the claim, and Explanation of Benefits report issued by the primary company.