

Claim Form

FOR OFFICE USE ONLY			
Claim No.			
CO-INSURANCE		DEDUCTIBLE	

I-PRINCIPAL INSURED INFORMATION					
Full Name:			Policy Number	Date of Birth (MM/DD/YYYY) / /	
	Name(s)	Last Name			
Residential Address:					
	Street	City	State	Country	Zip Code
Email Address:		Residential Telephone:		Cellular Number:	

II-PATIENT INFORMATION (If different than Principal Insured)					
Full Name:				Date of Birth (MM/DD/YYYY) / /	
	Name(s)	Last Name			
Residential Address: (if different than the Principal Insured)					
	Street	City	State	Country	Zip Code
Email Address:		Residential Telephone:		Cellular Number:	
Full Name of the Primary Physician and Specialty (Internist, Pediatrician, Gynecologist, etc.)					

III- ADDITIONAL INSURANCE COVERAGE		
Does the patient have other health insurance or similar policy in force?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Has the patient requested, or will request reimbursement of expenses for this event thru another insurance company, entity or plan?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Amount of reimbursement requested: :	Name of insurance company, entity or plan:	Policy Number:

IV-PHYSICIAN INFORMATION					
Full Name:			Specialty:		
	Name(s)	Last Name			
Address:					
	Street	City	State	Country	Zip Code
Email Address:		Telephone:		Fax:	

V- CASE DATA		
Event Type: <input type="checkbox"/> Illness <input type="checkbox"/> Treatment <input type="checkbox"/> Accident <input type="checkbox"/> Maternity <input type="checkbox"/> Hospitalization <input type="checkbox"/> Other: _____		
Diagnosis or Symptoms:	Description of the treatment, procedure or surgery:	Date of Service (MM/DD/YYYY) / /
Place where services were rendered to the patient: <input type="checkbox"/> Doctor's Office <input type="checkbox"/> Laboratory <input type="checkbox"/> Emergency Room <input type="checkbox"/> Hospital <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

VII- PHYSICIAN STATEMENT (if have completed this form)		
I hereby certify that the information provided in this claim form is accurate and complete.		
_____	_____	_____
Physician's Signature	Medical License Number	Date (MM/DD/YYYY) / /

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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: riclaims@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.