CLAIM FORM

with filing instructions

Please follow these instructions prior to filing a claim and when completing the Claim Form. Assistance is also available from the Customer Service Department at the telephone numbers listed below.

IF YOU HAVE NOT YET RECEIVED TREATMENT:

Pre-certification (notification of illness or accident):

You must call to pre-certify any of the following conditions: any treatment requiring hospitalization; outpatient surgery, CAT scans, MRI's; within 48 hours after an emergency admission to the hospital; care in an extended care facility; home nursing care; durable medical equipment including artificial limbs; or transplants. Pre-certification may be done by you, a relative, or a hospital representative.

IF YOU HAVE ALREADY RECEIVED TREATMENT:

- If this is a new claim, complete ALL PARTS of the Claim Form. If treatment was received in the United States you don not need to complete PART C.
- If this is a continuing claim, complete PARTS A AND D. If treatment was received outside of the United States, you should also complete PART C.
- Attach all original itemized bills, statements and invoices for services and supplies.
- Please make certain that all documents indicate claimant's name, date of service, diagnosis and the itemized charges.

Mail the completed form to either:

Access HMO
2885 Sanford Avenue SW
Claims Dept. #27044
Grandville, MI 49418 USA
Phone: +1-616-723-0580 (In US)
+420.777 735 359 (Outside US)
Email: claims@accesshmo.com

Our goal at Access HMO is to process your claim quickly, accurately and efficiently. In order to achieve this, the Claim Form must be fully and accurately completed. Failure to do this will result in processing delays.

Claim Form & Authorization

DIRECTIONS FOR SUBMITTING A CLAIM

(There are four parts to this form – A, B, C & D. Please carefully review the instructions below.)

- If this a new claim, complete ALL PARTS of this form. If treatment was received in the United States you don not need to complete PART C.
- If this is a continuing claim, complete PARTS A AND D. If treatment was received outside of the United States, you should also complete PART C.
- Attach all original itemized bills, statements and invoices for services and supplies.
- Please make certain that all documents indicate claimant's name, date of service, diagnosis and the itemized charges.

FOR FASTEST SERVICE PLEASE EMAIL ALL CLAIMS TO: claims@accesshmo.com

or mail to:

Access HMO
2885 Sanford Avenue SW
Claims Dept. #27044
Grandville, MI 49418 USA

Notice: Any false statement, concealment or fraud shall render this insurance null and void and all claims hereunder shall be forfeited.

PART A. To be completed and signed by the Claimant for all claims.

Patient Name:		
☐ Male ☐ Female	Date of Birth:	
Patient's Relationship to Primary Insured	☐ Self ☐ Spouse ☐ Child ☐ Other	
Name of Primary Insured:		
☐ MaleFemale ☐ Date of Birth:		
Home Country Address:		
Current Address:		
Home Phone:	Work Phone:	Email:
Are you U.S. Citizen: ☐ Yes ☐ No		
How many months of the year are you in the U.S.?		

PART B. To be completed by the Claimant for new claims only. (If you need additional space, please attach a separate sheet)

1. Did you receive treatment for your condition in the United States? ☐ **Yes** ☐ **No**

2. How did the condition begin? State fully all symptoms and describe the condition in detail from the beginning.

For accidents, include how, when and where the accident occurred.

3. When did the first symptom of this condition begin? State the exact date if possible.

4. Have you ever had or been treated for this type of injury or illness before? ☐ Yes ☐ No

5. List all the names and addresses of the providers you have seen for this condition.

6. What ailments, diseases, illness or injuries have you experienced during the last five years? Please provide the name and/or description of each condition, dates and name and address of the attending physician(s).

7. Is this condition the result of an accident or illness:

a. Related to employment? ☐ Yes ☐ No

If yes, are you applying for Worker's compensation benefits? ☐ Yes ☐ No

b. Involving a motor vehicle? ☐ Yes ☐ No

If yes, please list the names of involved parties, insurance carriers and policy number.

c. **Was a police report filled?** ☐ Yes ☐ No

If yes, please identify the Police Department where it was filled.

8. Was the accident related to an organized or sanctioned athletic activity, involving regular or scheduled games and/or practices? ☐ Yes ☐ No

9. In the event you have hired legal counsel, please provide IMG with the complete name, address and telephone number of the attorney

PART C. Complete for all treatment received outside of the United States.

Date of Service Mm/dd/yr	Provider	What type of service and/or name of drug provided?	What was the illness/injury?	City/Country	Type of currency paid or billed	Total charge paid or billed	Converted to US funds	Office use only

PART D. Authorization – to be completed by the Claimant for all claims.

I verify that all information contained in this form is true, correct and complete to the best of my knowledge.

I authorize any licensed doctor, practitioner of the healing arts, hospital, clinic, health related facility, pharmacy, government agency, insurance company, group policyholder, employee or benefit plan administrator having information as to the care, advice, treatment, diagnosis or prognosis of any physical or mental condition, or the financial or employment status of the insured named below, to provide this information to Access HMO or any agent or administrator acting on its behalf.

I understand that I have the right to receive a copy of this authorization upon request. A copy of this shall be as valid as the original.

Print Name of Insured ______________________________

Signature of Insured/ Guardian ______________________________ Date ______________

AUTHORIZATION: I authorize payment of medical benefits to the doctor or other supplier of the services submitting the attached bills.

Signature of the Insured/Guardian ______________________________ Date ______________

PRIVACY AND CONFIDENTTIALY RELEASE FORM

By completing this form, you are providing your consent to Access HMO to discuss your claim activity with the person(s) listed below. Without this release form, Access HMO cannot discuss your claims activity with anyone other than your physician(s) or provider (s) of service.

I authorize Access HMO to discuss my claim activity with______________________________________.

This authorization is valid for________months from the date signed.

I give Access HMO permission to release any or all of the following information:

(Please select and initial)

☐ ____ All financial and claim information related to medical bills or Claimant´s / Client´s / Patient´s Statement and Authorization

☐ ____ Provider name, date of service, total charge, total paid and date of payment

☐ ____ Insurance ID number and /or social security number

Under no circumstances can Access HMO release medical information obtained from your physician or provider of service to you or anyone. Your medical information has been disclosed to us from your physician or provider of service and we are prohibited by law for further disclosure. Please contact your physician or provider of service for your medical information.

_____________________________________ Print Patient name

_____________________________________ Insurance ID Number

____ Signature of the Patient or Insured Person if the patient is a monir child

_____________________________________ Date

Please provide your current mailing address:

Street Address	
City	State, Country, Post Code

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or mail to:

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