Inter **Hannover**

Group Name: ___________________________

CLAIM FORM FOR MEDICAL EXPENSES INCURRED IN THE USA

Please complete this claim form and return to Olympus Managed, this form is required in order to complete the reimbursement process. Please complete form in BLOCK CAPITALS. Also, please provide full supporting documentation to avoid delays in processing your claim.

You may submit the completed form via email to: Interhannover@omhc.com or by mail to:

Olympus managed Health Care

777 Brickell Avenue, Suite 410, Miami, FL 33131

Claimant First Name	Claimant last name	Date of Birth	Policy/ID or cert #

Claimant Complete Address: ____

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Is this the address where reimbursement should be sent to? ______________________________

Email address: ___________________________ Telephone #: ______________________________

DOCUMENTS REQUIRED TO SUPPORT CLAIMS:

- Copy of Itemized bill/statement
- If this is a reimbursement claim, provide copy of receipts
- Explanation of benefits from your primary insurance, if applicable
- Medical report or records given by the physician, medical center or hospital, including diagnosis and treatment

CLAIM DETAILS

Date, time and place of illness, injury: ____

Period of treatment, if applicable: From:________________ To: _____________________

Description of injury or illness:

____

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Previous History/ Onset of symptoms: ____

If injury, provide details: ____

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Did you contact us at the time of the injury, illness? ____________________________________

Have you been covered by any other group plan, health maintenance organization, government plan or insurance policy in the past 12 months? If yes, give details: ________________________

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I hereby certify the above information given is true and correct:

Patient or authorized representative Signature: ____________________________

Date: __________________________

Amount of expenses being claimed and currency	**Treatment received**	**To Whom Should payment be made**

REIMBURSEMENT DETAILS

DECLARATION

I declare that the information provided in this form is true and correct to the best of my knowledge. I have not withheld any information within my knowledge. I agree to provide additional information as reasonably required to complete the claim process.

DATA PROTECTION ACT

The insurance industry operates a number of anti-fraud initiatives. The information given on this form may be stored electronically and may be shared with other organizations for this purpose. I understand that you may ask other organizations for information to verify information provided on this form.

DISCLAIMER

I hereby authorize the insurance company to obtain information related to my treatment and condition:

Received at: ____

From (date of accident/illness): ____

Signature: ____________________________ Date: _____________________________________

Please provide details of where to submit reimbursement, if different than what was provided on page one:

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