☐ SUBMIT CLAIMS TO:

Morgan-White Administrators International, Inc.
3191 Coral Way,Suite 704, Miami, Fl 33145
Tel.: (305) 442-0899 • Fax: (305) 442-0961

INSTRUCTIONS HOW TO COMPLETE THE HEALTH INSURANCE CLAIM FORM

1. Answer all questions on Part 1 for each insured person. Date and signature.
2. Ensure that the treating doctor completes Part 2 on the reverse side. Date and signature.
3. Return the complete claim form with invoices and original receipts to the above address within the first 90 days of the treatment.
4. Complete a separate claim form for each illness or accident.
5. Dependent children 18 years old and over should include copy of the school certificate.

Part 1 - PATIENT INFORMATION

Name of Main Insured: ____________________

Address: ____________________

Telephone No.: ____________________ Policy No.: ____________________

Date of Birth: ____________________ Sex: Male __________ Female __________

Name of Patient or Dependent: ____________________ Sex: M _____ F _____

Date of Birth: __________ Relationship: __________ Married: _____ Single: _____

Do you have any other health insurance? Yes _____ No _____

Name of Insurance Company: ____________________

Address: ____________________ Policy Number: ____________________

Complete for all injuries:

Date of injury or accident: ____________________

How did injury or accident occur? ____________________

Is injury due to automobile accident? Yes _____ No _____

Did the injury occur while working? Yes _____ No _____

Nature of illness and date upon which first symptoms occurred:

Name and address of personal attending/Family Physician:

Are you currently under medical observation or treatment, or taking any prescribed drugs? If so, please give name and address of treating physician, treatment and medication:

Give name and address of physician(s) who treated you and/or to whom you have been referred for diagnosis and treatment of above mentioned illness:

Have you received treatment for the same condition before? Please state name and address of treating physician/facility:

Have you received any medical treatment of any kind in the past 10 years? (Give name and address of treating physician):

The above answers are true and complete to the best of my knowledge and belief. I authorize any physician, medical institution, insurance company, employer, labor union or association to release information to **Morgan-White Administrators International, Inc.** as is required to properly process this exam. A photostatic copy of this authorization shall be considered valid as the original.

Date: __________ Signature: ____________________ (Insured)

Signature: ____________________ (Patient) If minor, Parent

Part 2

HEALTH INSURANCE CLAIM FORM

TO BE COMPLETED BY THE TREATING PHYSICIAN

Name of Patient ________________________ Date of Birth ____________ Sex: M ____ F ____

Date patient first consulted you ________________________

Please state date on which first symptom/accident occurred: ________________________

Please state date on which patient first consulted you for this condition: ________________________

Prescription of drugs given for this condition, please state name of drug and dosage: ________________________

Please give your diagnosis of the illness/injury:

Will illness/injury require follow up treatment? If so, please give details:

Has diagnosis and/or treatment for same or any related condition been given previously? If so, please state date(s), result(s), kind of treatment/prescribed drugs and name of treating physician/facility:

Has patient been referred to you by another physician? If so, please give name and address of referring physician:

In case of claim for maternity, please indicate:

1) Date of last menstrual period:
2) Uterus enlarge measurement:
3) Time period of pregnancy:
4) Expected date of delivery:

Date of Services	**Describe medical procedure. Please describe medical services or supplies furnished for each date given.**	**Charges**	
	Total amount due		
	Amount paid by patient		
	Balance due		

Signature of Treating Physician ____________ Number of Medical License ____________ Date ____________

Name, adress and telephone number of treating physician or treating facility:

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